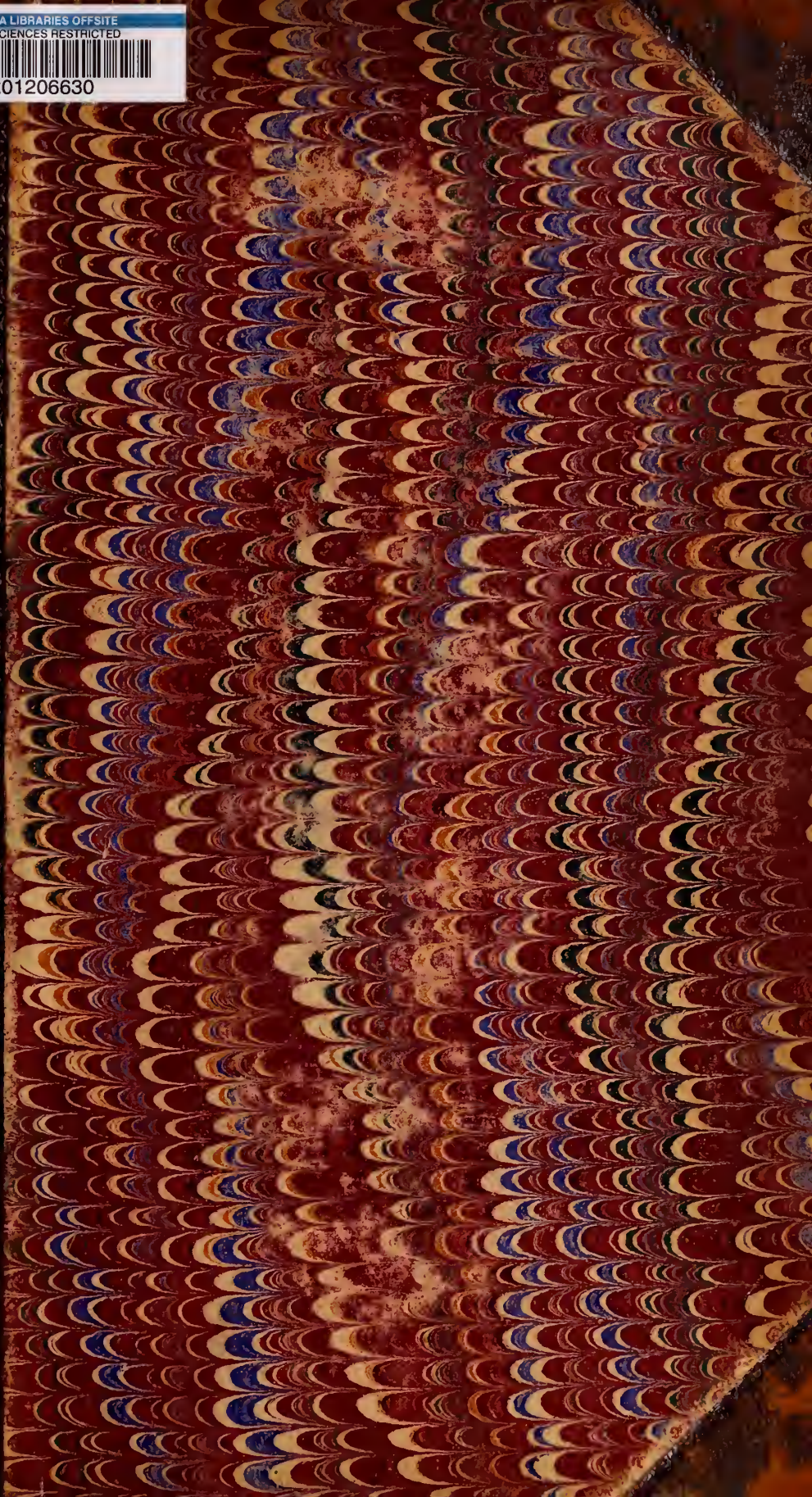


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OF
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EDITED BY
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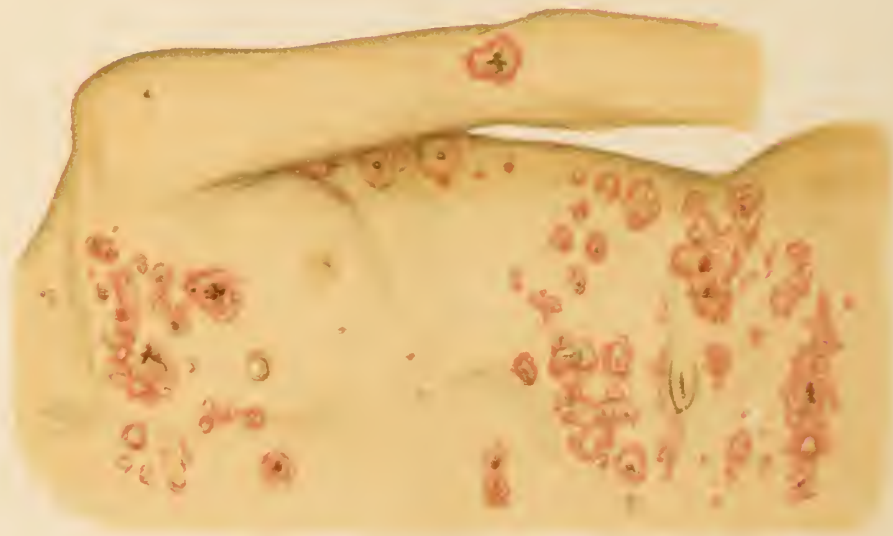
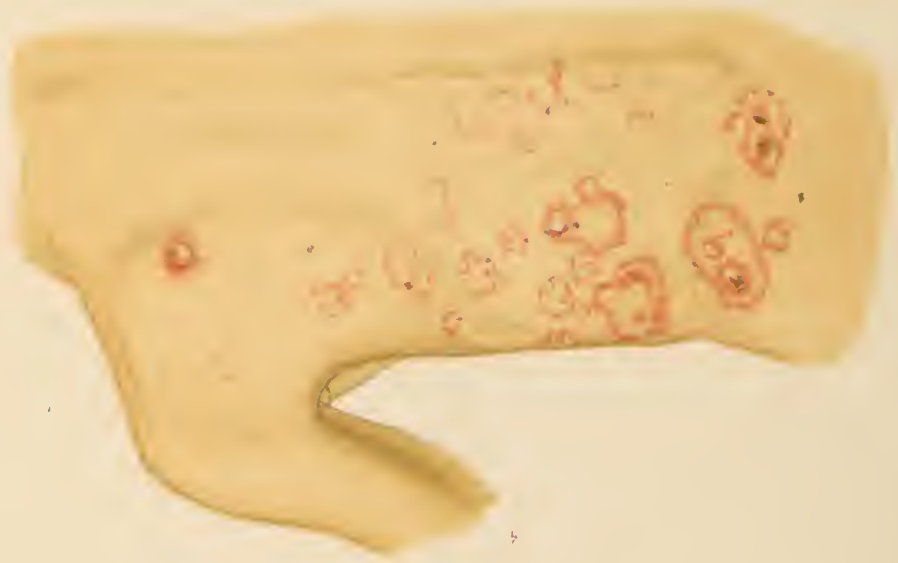


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Impetigo (dermatitis herpetiformis)

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No. 1.

Original Communications.

HYDROA; IMPETIGO HERPETIFORMIS; DERMATITIS HERPETIFORMIS.

BY

A. R. ROBINSON, M.D.,

Professor of Dermatology at the New York Polyclinic, etc.

AS the eruption which is represented in the accompanying illustration is a comparatively rare affection, and is at present the subject of considerable attention on the part of dermatologists, especially in America, I have considered it not inappropriate to publish a lithographic drawing of a well-marked case, together with a few remarks upon the subject. What the eruption should be called is still an undecided question, for though the name dermatitis herpetiformis, as given to it by Dr. Duhring, who has carefully studied the subject, has been accepted by the American Dermatological Association, yet it has not by any means been shown that the term hydroa, as first proposed by Bazin for certain eruptions resembling on the one hand herpes, and on the other pemphigus, is not in its proper acceptance sufficiently broad to include all these papular, vesicular, pustular, and bullous forms of eruptions which have been described under the terms impetigo herpetiformis, dermatitis herpetiformis, pemphigus hystericus, and herpes gestationis. After considerable study of the literature of the subject, and from my own observations on a number of cases which I have lately seen, I feel inclined to agree with the views of the late Dr. Tilbury Fox, as given in a most excellent article on hydroa in the *Archives of Dermatology* for 1880, wherein he distinguishes three varieties of the disease, viz., H.

simplex, H. herpetiforme, and H. bulleux s. pruriginosum. Further observation may enable us to separate these forms of eruption, or what is more likely, to include other forms produced by the same pathological agent or factor, as it is clear that the skin lesion is not a simple, local, idiopathic affair, but the result of some disturbance more general and deeper-seated, but whose nature we do not yet understand; consequently the skin lesion must vary in accordance with the intensity and duration of action of the producing agent, as well as from the ability of the skin to withstand the injury, and as a result, we may have a papular, vesicular, pustular, or bullous eruption, the arrangement of the lesions depending upon the nervous system and thus giving the herpetiform character generally observed. That the form of lesion present often depends upon the three factors above mentioned and not upon any difference in the producing agent, is shown by the disposition of one variety to pass into another, as well as by the multiformity of lesions present on the body at the same time. Until it has, therefore, been shown that the term hydroa, in the extended sense employed by Tilbury Fox, does not include the varieties described by Dr. Duhring and others, I do not feel justified in accepting the names lately proposed. To show how previous views required modification, it was formerly thought that that variety described by Hebra under the term impetigo herpetiformis was invariably fatal, whilst we now know that such is not the case; and further, that the herpes gestationis variety occurred only during pregnancy, when in fact it may be absent during pregnancy, to occur soon after parturition, as observed in one of my own cases in two successive attacks.

The subject is one which requires much further study before our ideas can be clear and definite in the matter. We owe much to the excellent papers lately published by Dr. Duhring, and hope other observers will follow in his footsteps.

History of case represented in plate. August 15th, boy, aged ten years, newsboy by occupation, medium size, and fairly nourished. The parents are healthy. Has one brother three years older, who has always been healthy. Three years ago he had an eruption which he says resembled the present one, and lasted several months. About ten months ago he had probably a mild attack of joint rheumatism. The present eruption was not preceded by any constitutional symptoms noticed by the patient, and commenced about two months ago, first on the ankles as clear bullæ, and later on the rest of the body. It is now abundantly present on the thorax, abdomen, lower and posterior part of scrotum, and especially on the whole of the inner surface of the thighs, and scanty on the legs and upper extremities. The soles of the feet and palms of the hands, as well as the mucous membrane of the mouth, are free.

The eruption commences as papules, vesicles, or bullæ, and forms at

present pin-head-sized to two inches or more in diameter irregularly-shaped patches. The pin-head-sized spots are red, elevated, inflammatory papules, which contain a little serum in their apex. The large patches consist of vesicles or bullæ, intact or ruptured, arranged in groups or rings and seated upon an inflamed and infiltrated base, or the patch has a more or less clear centre.

The collection of serum in the apex of the papules soon increases in quantity, and the papule becomes a well-marked vesicle seated upon a hardened inflamed base. The vesicle soon becomes flatter, at the same time it increases in size by peripheral extension. In many cases this extension at the periphery continued until the spot obtained a considerable size; at the same time the centre gradually returned to a normal condition, and producing appearances somewhat similar to those of ringworm of the body, except in the size of the vesicles at the spreading margin. On the back, most of the spots commenced as papules, and never became vesicles, but spread peripherally in exactly the same manner and with the same appearances as regards the lesion as occurs in ringworms, so that from these patches alone it would not have been possible to make a diagnosis without the aid of the microscope. Neighboring rings sometimes coalesced with resulting gyrate-formed patches. Sometimes a new lesion would form in the cleared centre of an older patch, usually a bullous lesion, which soon became opaque and dried to a crust, either with or without previous rupture. In many of these ringworm-like patches, close examination would detect small vesicles in the spreading margin, and there was less desquamation than is often observed in the parasitic disease. They sometimes attained a diameter of two or more inches, and the central part was either normal or contained a bulla, or dried crust, or was erythematous, and covered with slight scales.

Some spots commence as pea-sized or smaller bullæ, with walls and clear contents, situated upon an erythematous base and having a larger or smaller red areola. The bulla soon increases in size and becomes opaque, and new bullæ arise around it, giving the eruption an annular form. This arrangement of the secondary bullæ in an annular form around the primary bulla was a marked feature of the eruption on the anterior surface of the abdomen and thorax. Neighboring patches uniting, gave irregularly shaped, reddened, inflamed, and infiltrated areas covered with larger or smaller bullæ, or later presenting an excoriated surface with sero-purulent secretion and crusts from this secretion or from the contents of the bullæ.

The drawing should be studied by the aid of a magnifying glass, in order to properly observe the small vesicles at the periphery of the patches.

Sometimes around a central bulla the eruption spreads at the periphery as a raised, reddened, infiltrated area without the formation of

secondary bullæ, or the central bulla dries up, and new bullæ arranged in an annular form develop around it.

Two or more of these herpetic rings sometimes formed around this central bulla, or neighboring patches would coalesce to form the excoriated-looking patches already described, the whole patch resembling later *eczema rubrum*. This was especially the case on the inner surface of the thighs.

Isolated bullæ resembling a varicella or a pemphigus bulla, according to its size, were here and there observed, whose contents became opaque and dried up, without secondary bullæ forming. Bullæ sometimes as large as a walnut were observed and could not be distinguished from ordinary pemphigus bullæ.

The whole eruption was characterized by the grouping of the lesions, their arrangement in annular form or circles as in ringworm, in consisting of papules, vesicles, or bullæ, by intense itching and by marked pigmentation upon their disappearance. The pigmentation, of course, was due to the escape of hæmoglobin into the tissues in consequence of the scratching, more than from spontaneous hemorrhage, as very few bullæ contained blood.

Individual lesions lasted two to three weeks. He was given Fowler's solution, nine drops, three times a day; in a few days there was marked improvement, and in two weeks the eruption had entirely disappeared.

Nov. 28th.—Eruption has reappeared in the same form upon the inner side of the thigh and on the scrotum. I have excised a forming vesicle, and will report later the anatomy of the lesion.

PUERPERAL ERYTHEMA.

BY

J. CLARKE THOMAS, M.D.,

Obstetrician to the New York Infant Asylum.

IN puerperal septicæmia variable skin eruptions are met with. Of late considerable attention has been given them by dermatologists. The erythematous variety, the so-called scarlatiniform rash, has been termed the "Polymorphous or Multiform Erythema of Puerperal Infection" (J. Geneix, Th. de Paris, 1883).

Its etiological pathogenesis is the septic germ irritating the central nervous system, and causing vasomotor paralysis. It is frequently confounded with scarlatina in the puerperium.

Its diagnosis from scarlatina is often difficult. The absence of the history of the prodromata of scarlatina, and the absence of throat symp-

toms, the moderate temperature and the moderate amount of constitutional irritation, the history of the development and decline of the eruption, and the character of the desquamation are the differential points in the diagnosis. The following cases were met with at the New York Infant Asylum.

CASE I.—Mathilda Stroll, German, twenty-five years; primipara, labor normal, delivered October 22, 1883.

Day....	3		4		5		6		7		8		9		10	
	M	E	M	E	M	E	M	E	M	E	M	E	M	E	M	E
Temp...	102 $\frac{1}{2}$	99	100 $\frac{3}{5}$	99 $\frac{1}{2}$	101 $\frac{3}{5}$		Normal		Normal		Normal		100 $\frac{3}{5}$	101 $\frac{3}{5}$	100	103 $\frac{3}{5}$
Pulse...	104	76	80	96	96		Normal		Normal		Normal		104	92	84	98

An eruption of an erythematous character was first noticed in the evening of the *ninth* post-partum day on the neck, chest, and back (between the shoulders). It was bright red in color. It was diagnosed as a scarlatinoid eruption by the resident physician.

The general condition of the patient up to her ninth post-partum day was good; her convalescence appearing to be normal. Her lochia were natural in amount, odor, and color. Her appetite was good. October 30, her eighth post-partum day, she complained of "chilly sensations up and down her back," headache and moderate constitutional irritation nearly all day.

At 3 P.M. October 31, ninth post-partum day, she was seized with a hard chill that continued for fifteen minutes. In the morning of Nov. 1, the eruption had extended to the ankles. In the evening, the resident physician regarded the case as suspicious and isolated the patient in the "quarantine." Prof. J. Lewis Smith happening in the asylum late in the evening, was requested by the resident physician to see the case. He regarded it as doubtful, but was inclined to believe it to be a "septic rash." Nov. 2, Dr. H. G. Piffard was called to the case, and made a diagnosis of "puerperal erythema."

The eruption gradually faded and disappeared on Nov. 6. Desquamation began Nov. 3 on the neck and face; it was furfuraceous in character. On the chest it began Nov. 7, and was in large and irregular strips. Nov. 18. The desquamation is still in progress on the arms and legs. The appetite is good. Still in bed. Complaints of nothing.

There is no history of specific or malarial infection. There was no throat trouble before or during her eruption. The only medicine given was gr. xx. bromide of sodium on the evening of Oct. 30.

After the eruption was diagnosed, sulphate of quinine, in gr. v. doses, was given.

CASE II.—Alicie Wood, England, twenty-two years; primipara, delivered Nov. 11, 1883; labor normal.

Day...	1	2	3	4	5	6	7	8	9	10	11	12
Temp ..	M	M	M	M	M	M	M	M	M	M	M	M
	99	99 $\frac{3}{8}$	99 $\frac{3}{8}$	99	98.3	99.5	99.1	99.2	98.4	99	98.3	98.4
	E	E	E	E	E	E	E	E	E	E	E	E
	99 $\frac{1}{2}$	99 $\frac{3}{8}$	100	100.1	100.1	100.3	100.2	100.2	99.3	99.2	99	100.1
Pulse...	M	M	M	M	M	M	M					
	96	88	84	80	84	96	80					
	E	E	E	E	E	E						
	84	80	100	80	100	100						

Her convalescence was normal up to the evening of Nov. 16, her fifth post-partum day, when an erythematous eruption was detected on the upper portion of her chest and back. Nov. 17. The eruption was well-defined, bright red in color, and extended over the entire trunk of her body and on to her thighs.

She complained of a sensation of "pins and needles" over the surface of the body, and of chilliness, lasting nearly all day. No medicine had been administered with the exception of fld. ext. ergot immediately after her confinement. Nov. 18. The eruption had spread to her feet. The prickling sensation on the surface still continued. Her lochia were normal, as was also the mammary secretion. There were no throat symptoms. The case being regarded as suspicious, Dr. H. G. Piffard was called. He diagnosticated puerperal erythema.

The desquamation was protracted, lasting seven weeks. It was irregular. It was repeated in the same localities. It appeared last on the back and chest. It was mostly in large scales. Her appetite was good.

She was isolated in the quarantine, as a mere matter of prudence.

In these two cases the eruption

(a) Resembled that of scarlatina.

(b) It extended slowly from the upper portion of the body to the lower extremities.

(c) There were no throat symptoms.

(d) There was but little constitutional irritation, as measured by fever and depression of vitality.

(e) The desquamation was irregular as to character, duration, and recurrence.

(f) The possibility of their origin being from drugs was readily excluded.

In examining the asylum records, we have found the following history of a somewhat similar case:

Maggie Jones, twenty-five years, Wales, primipara, healthy. Family history good. She was confined at the asylum, October 18th, 1882. Labor was normal. Infant was a female.

TEMPERATURE.

Day..	1	2	3	4	5	6	7	8	9	10	11
	M	M	M	M	M	M	M	M	M	M	M
		99 $\frac{3}{8}$	100 $\frac{3}{8}$	102 $\frac{3}{8}$	100 $\frac{3}{8}$	100	100 $\frac{3}{8}$	99	99 $\frac{1}{2}$	99 $\frac{3}{8}$	99
	E	E	E	E	E	E	E	E	E	E	E
	101 $\frac{1}{4}$	102 $\frac{3}{8}$	103 $\frac{1}{4}$	104	103	102	100 $\frac{3}{8}$	100 $\frac{1}{2}$	99 $\frac{3}{8}$	100 $\frac{1}{2}$	100 $\frac{3}{8}$

PULSE.

1	2	3	4	5	6	7	8	9	10	11
M	M	M	M	M	M	M	M	M	M	M
90	90	96	88	88	84	80	84	80	80	84
E	E	E	E	E	E	E	E	E	E	E
90	96	132	92	96	88	84	84	88	84	84

On the morning of the *second day after delivery*, a bright red and slightly elevated, discrete eruption appeared on the *lower extremities* and gradually, during the day, extended up the back and on to the chest. In the evening the eruption had become confluent upon the lower extremities, and resembled that of scarlatina. There were no throat symptoms. The fever was moderate.

On the third day the eruption became diffuse on the back, chest, and upper extremities. On the back it was somewhat elevated, in wheals.

On the fourth day the eruption began to fade, and on the eighth day had entirely disappeared.

No desquamation followed. Lochia were normal. Mammary secretion was normal.

The patient did not complain of anything except a sensation of intense irritation of those portions of the surface invaded by the eruption.

PELIOSIS RHEUMATICA.

BY

ETIENNE C. VIDAL, M.D.,

New York.

JUNE 12, I was consulted by H. B., male, twenty-five years old, native of Germany, for an eruption situated on the lower extremities, accompanied by œdema of the ankles, and a "sticking, cutting, pain" in these articulations. The right ankle was considerably swollen and covered with a confluent efflorescence of a purple hue. Above this latter, and extending to the knee, were smaller patches varying in size from that of a ten-cent piece to that of a silver dollar. In addition to these were maculæ, round in form, and the size of a lentil. Their color, a brighter red than the above-described efflorescence, persisted under finger pressure. On the left ankle, the color of the eruption was brighter than that of the right. It assumed sharply defined forms, leaving the anterior aspect of the articulation entirely free. The inferior portion of the left leg as high as the knee was covered with an eruption similar to that on the right. There was less pain and œdema in the left ankle. The dorsal surface and the sides of both feet presented the same variety of maculæ; they likewise existed on the back of the hands. A few very

indistinct spots of a pale-yellow color offered on the palms of the hands. The patient suffered from fever and headache; he had no appetite, was weak, and presented a general anæmic condition. Walking was exceedingly painful and increased the swelling.

The patient informed me that, three evenings before his visit to me, he had been out drinking. The following morning, he experienced pain in the ankles, and found that they were swollen. During the day the spots appeared on the legs, and in the evening fever set in. The second day the spots were seen on the hands and feet. When I saw him at the consultation, on the third day, the efflorescence had partially disappeared, there was less oedema, he had no fever, no headache, appetite good, but the urine was colored. On the third day after I saw him, the eruption disappeared; the swelling, a day later. There was no relapse, the disease having run a course of ten to eleven days.

The horizontal position, tinct. ferri chlor., and cold-water dressings constituted the treatment.

CONGENITAL CONTRACTION OF THE MEATUS URINARIUS.

BY

MAHLON HUTCHINSON, M.D.,
Chicago, Ill.

I DESIRE to report the following cases for the reason that I have seen so many examples of contraction of the meatus urinarius, giving rise to reflex troubles, and occurring in patients treated by various physieians and surgeons who did not deem it necessary to operate, but contented themselves merely with giving internal medicines.

CASE I.—Mr. C. C. C., aged twenty-eight, married, consulted me on November 22, 1882, for a presumed organic urethral stricture. He had been subject to sudden attacks, occurring every six weeks or two months, for the past six years, of inability to urinate. Eight years before, he had contracted a gonorrhœa, which lasted about two months, and was cured with but little difficulty. He, of course, referred his subsequent attacks to that gonorrhœa, and had been confirmed in his belief by consultation with six surgeons, two in Buffalo, N. Y., two in New York City, and two (prominent) ones in Chicago. They all agreed in a diagnosis of organic stricture, and advised strongly an operation. Four of them had passed catheters during his several attacks, and, with great difficulty and considerable pain and the drawing of some blood, had succeeded in reaching the bladder and relieving him for the time being. The patient was a large man, weighing over two hundred, of full habit, and of very passionate nature. He informed that, during his married life of six years, he

had probably had connection with his wife once a day on an average. Upon examination of patient's genital organs, I found a small penis, very much retracted, with a meatus the size of a pin's head, reddened and inflamed. Upon attempting to introduce a sound, I found the urethra so irritable that Mr. C. was unable to stand the pain. I decided that the first, and probably the last, thing to do was to slit the meatus. I scarcely thought there could be any organic stricture, for between the attacks of the complete stoppage of urine the flow was as full and as free as if from a perfectly healthy urethra. Telling Mr. C. what I desired to do, he strongly objected, dreading, above all things, the use of the knife. He was brought to terms, however, by another threatening attack, and coming to my office on December 5th, 1882, the simple operation was quickly performed, and the patient dismissed. The after-treatment was the introducing of a pellet of cotton to keep the cut surfaces apart, and, without the administration of a single dose of medicine, Mr. C. has remained well, never having had an attack since the day he was operated on.

CASE II.—Mr. Geo. S. was first seen by me on February 20, 1882. He complained of inability, at times, to hold his water, frequent micturition, and sudden and imperative calls to urinate. Upon examination, I found a meatus quite small and divided in two parts, forming two openings, by a tissue band. I immediately divided this band and enlarged meatus by an eighth-of-an-inch cut, and prescribed an alkaline mixture, the basis being *potassæ citrat*. Patient seen three months thereafter; had had no return of his previous symptoms.

CASE III.—Mr. M. A., age nineteen, single, an upholsterer by trade, was first seen by me on October 6, 1884, and is at present under treatment. Patient's history was that he masturbated from the age of fifteen to seventeen; that he then gave up the habit, and began to relieve himself by indulging in intercourse regularly every five or six weeks; that, up to six months ago, everything was natural and right, but that one night he suddenly found himself impotent, unable to command an erection; and that, although his attempts have been frequent, he still remains in the same unfortunate condition. Nocturnal emissions, without dreams, have occurred twice a week for past three months. Upon examination, I found a shrivelled penis, and meatus no larger than that described in case I. I immediately slit it. Treatment since has consisted in the passing of the cold sound and the administration of bromides and *Fl. Extr. Gelsemii* (Gross), to reduce the very irritable condition in which I found the prostatic urethra. Mr. A. feels very much encouraged over the rapid improvement obtained in the condition of his genitals, as regards irritation and the cessation of the nocturnal emissions, and is as confident as I that it is only a question now of a little time until his sexual strength is fully restored.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

149TH REGULAR MEETING.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. KEYES presented a case of

PERSISTENT SYPHILITIC ROSEOLA.

James —, two and a half years old, has albuminuria, parenchymatous nephritis, oedema, and bronchitis. He has a general eruption of syphilitic roseola, which made its appearance four weeks ago and has remained ever since. On the right side of the anus the primary lesion can still be seen. The mother and father are perfectly healthy. The mother has never had any miscarriages.

DR. FOX exhibited a case of

SYPHILIS MODIFIED BY ECZEMA.

A woman about fifty years old. Has had the present eruption off and on for the past five years, and during that time has been subject to attacks of rheumatism. Now she has an eruption with a rather well-marked margin, extending on both the radial and ulnar side of the left forearm to near the middle, where the two portions of eruption form a band about two inches broad across the posterior aspect. The lesion is also found on the ulnar side of the hand, also on the knuckles, as well as on the back of the middle, ring, and little fingers. At the bifurcation of the fingers the skin is healthy. A patch of eruption is also to be seen on the ulnar side of the right hand, above the little finger. No eruption on the palms, or elsewhere on the body. The treatment has been acetate of potassa internally, and ointment of oxide of zinc externally, without much benefit.

DR. JACKSON said that when he first saw the case, some time ago, he believed it to be psoriasis, there being nothing in the appearance of the lesion to suggest syphilis, except the raised border.

DR. MORROW believed the case to be one of eczema, pure and simple, and he did not think that there were any modifying effects of syphilis present.

DR. SHERWELL was abundantly well satisfied that eczema and syphilis can occur in the same person and at the same time; he, however, believed this lesion to be an eczema.

DR. KEYES said that he did not see anything in the appearance of the eruption that would lead him to believe that it was influenced by syphilis.

DR. STURGIS did not think that the external appearances showed that the eruption was modified by syphilis.

DR. ROBINSON said that he had seen many cases similar to this, modified by a rheumatic diathesis; he would regard this lesion as one of eczema of a chronic form. He did not think that syphilis would modify the form of an eczema, but that it would influence the course of the eruption.

DR. FOX said that he had believed and taught that syphilis does not modify the course of an eruption. He mentioned the case of a man whom he had hoped to present to the Society, and who had in some places orbicular patches of eruption tending to heal in the centre, in others there would be a healthy isthmus of skin between two diseased patches. In the case under consideration, the peculiar raised margin of the eruption, and the tendency to heal in the centre led him to suspect a syphilitic taint. He believed that the basis of the eruption was

syphilis, and that when the patient was put on anti-syphilitic treatment there would be an improvement, and final disappearance of the eruption.

DR. SHERWELL showed a case of

PEMPHIGUS CACHECTICORUM.

Bessie W., three and a half years old, has had the present eruption ever since January last. The lesion first made its appearance on the chin and around the lips as small bullæ. The mother says that when the eruption first appeared it looked as if the child had been scalded.

Now on the cheeks and chin is an eruption of broken-down bullæ, also similar lesions on the neck above the notch of the sternum, on the forearms, the inner side of both thighs, and in the popliteal spaces. On the buttocks, especially the left side, is a scattered, discrete eruption, greatly resembling scabies. No other members of the family have an eruption. The child appears to be in good health.

DR. FOX regarded the case as one of the commoner forms of dermatitis herpetiformis.

DR. STURGIS asked if you could get such enormous bullæ in dermatitis herpetiformis as were seen in this case; in all the cases he had seen the bullæ were not so large.

DR. ROBINSON believed the case to be one of dermatitis herpetiformis, the pustular form described by Hebra, because of the multiform character of the eruption. This case corresponded in many particulars with that lesion, the inflamed base to the eruption, the grouping, its itchy nature, the pigmentation, chronic course, and situation on the inner side of the thighs. He had had a well-marked case in which the eruption existed on the inner side of the thighs.

DR. SHERWELL said that he considered the lesion to be a pemphigus, necrogenic in character. During the French war he had seen similar cases occurring in persons where there was a tendency to pyæmia.

DR. KEYES then presented a

CASE FOR DIAGNOSIS.

Mary H., nine years old. The mother says that the child had brain fever four years ago; a year after, or three years ago in May, a bullar eruption made its appearance on the palms and soles, with papules on the back of the hands and arms, containing pus and itching greatly. It came in crops and lasted all summer, with intermissions of several weeks. Each new attack was announced by an outbreak of fever for twenty-four hours. Each October the eruption disappears and again appears each May. This year the eruption is worse than usual, some papules appearing on the neck. The general health is good. Soda relieves the itching.

DR. FOX showed a case of

RECURRING BULLOUS ERUPTION.

A well-developed child, two and one-half years old, has had a recurring eruption for the past two years. The lesion makes its appearance as vesico-pustules, the base then spreads and large bullæ form, which when they dry down leave scars with pigmented edges. The eruption is scattered mainly over the thighs and legs. The child was vaccinated when four months old. No history of eruption in the family.

DR. FOX afterward presented a

CASE FOR DIAGNOSIS.

A single woman, twenty-five years of age, has been troubled for many years

by outbreaks of eruption around the elbows and ankles, and recurring every two or three weeks. The eruption makes its appearance as vesicles in groups; soon after there is a hemorrhagic effusion into the vesicles, then they break down into ulcers with ragged edges. The ulcers are accompanied by considerable pain. There is slight itching of the affected parts. The general health is good, with the exception of increased frequency of menstruation.

DR. MORROW showed a case of

DISEASE OF THE NAILS.

Alphonse D., French, forty-four years old. Cook. There is no history of syphilis. The disease first began to develop three years ago upon the forehead at the margin of the hairy scalp. The patient first noticed a small itchy spot which gradually spread, soon attaining its present dimensions. Six months later, the disease appeared upon the outer aspect of the legs, midway between the knee and the ankle. Two years ago it commenced to develop upon the penis, and now involves the entire penis, scrotum, perinæum, and anal region. It also extends along the inner surface of the thighs and over the pubic region. The disease has within the last six months become generalized. There are scaly patches in the axillæ, in the popliteal spaces, with scattered patches upon the back, cheek, forearms, hands, and legs.

The nails began to be affected about eighteen months ago. The lesion commenced first upon the thumb and great toe nails, and afterwards extended to all the nails.

The patient states that the disease first attacks the base or side of the nail, and gradually affects the entire nail substance. All of the nails have been lost and some of them partially replaced by new nail growth.

It will be seen that the nail beds of most of the fingers are occupied by a thick, rough, uneven and friable substance of horny consistence which is easily detached and separated. Sometimes the nail gradually exfoliates, at other times it is detached *en masse*. The posterior and lateral cutaneous folds are unaffected, as in ordinary cases of eczema unguium.

DR. KEYES presented a case of

SYPHILITIC GUMMATA.

A boy, eighteen years old, has always had good health. Never had venereal disease, no keratitis, and no notching of the teeth. There is no history of syphilis in the family. Two years ago one of the patients' testicles was removed by Dr. Lange, on account of suppurative disease of that organ. Two months ago a large lump appeared on the left side of the forehead, which gradually increased in size until placed under treatment two weeks ago. There is also a smaller gumma situated beneath the left eye, and over the malar bone.

Two weeks ago, the gumma on the left side of the forehead was somewhat over three inches in diameter, that on the cheek being considerably smaller. Dr. Keyes recognizing the case as a late hereditary syphilide of a gummatous form, placed him on the mixed treatment. Since that time the lumps have been shelving at their base, and gradually growing smaller in size.

DR. BULKLEY exhibited a case of

PSORIASIS OF THE PALMS, ETC.

Elizabeth R., sixty-eight years old, widow, English, has had the present disease for thirty-five years. It first made its appearance on the dorsum of the

hands, in spots which gradually coalesced, forming patches that completely covered the hands. The patches were of a coppery color, covered with white scales of a bright glistening appearance. Four years afterward it appeared as scattered spots on the legs, arms and trunk, the lesions varying in size from that of a split pea to patches three or four inches in diameter.

When first seen by me, the whole body, with the exception of the face, was covered with coppery patches, having elevated and well-defined borders; these patches were deeply infiltrated and covered with thick white glistening scales, which on being removed left a purplish red base. On the extensor surfaces of the legs were excoriated patches, ranging from one to three inches in diameter, weeping, burning, and itching. The back of the hands, especially over the knuckles, were deeply fissured. The disease appeared on the palmar surfaces as small, millet-sized spots, covered with a thin scale leaving a smooth base on removal. The lesion also presented itself as hard, thick, fissured patches on the plantar surfaces of both feet. The legs were quite œdematous. She remained under my observation at the hospital for seven weeks, and was then discharged, being entirely free from eruption. The treatment was local only, chrysarobin pigment being employed.

The disease reappeared three weeks after leaving the hospital, first on the dorsum of the hands, and gradually spread until it again involved the arms, legs, thighs, lumbar and scapular regions. It also appeared on the dorsal and plantar surfaces of the feet. At present the legs are covered with thick, hard scales, especially over the anterior aspect. The patient is now being treated locally with chrysarobin, and internally is taking equal parts of mist. rhei et sodæ, and potas. acetat., twenty-five-per-cent solution.

DR. FOX then presented a case of

RECURRENT EXFOLIATIVE ERYTHEMA.

A woman, twenty years old, unmarried, Swedish, was first seen by Dr. Fox one week ago, when the hands presented an appearance resembling an ichthyosis, being very stiff, hard, and thickened. Even three days ago the eruption was well marked. The diseased skin could be very readily divided into several layers. Now the left hand is very greatly thickened and the hardened diseased skin is still seen to be made up of several layers. The right hand is much softer. She has had previous attacks of a like character, the lesion commencing as an erythema, followed by thickening of the skin, and finally ending in desquamation. A similar case has been described and illustrated in "Photographic Illustrations of Skin Diseases, Part II."

The Secretary then read the following on behalf of DR. PIFFARD:

CASE OF RECURRENT DERMATITIS EXFOLIATIVA.

I yesterday saw in consultation with Dr. Denhard a young man, seventeen years of age, who gave the following history: During the last twelve years he has had nine attacks of dermatitis exfoliativa. The attacks are ushered in by febrile symptoms, followed by the appearance of a scarlatinoid rash which after a few days gives rise to extensive exfoliations. The entire attack occupies about two weeks, and the patient's health in the intervals is good. I accompany this with specimens of casts of the palms and soles.

DR. KEYES afterward read the following paper, entitled:

NOTE ON HYDROCHLORATE OF COCAINE--ITS POSSIBLE DERMATOLOGICAL USES.

During the past two weeks I have employed the hydrochlorate of cocaine in

four-per-cent watery solution a great number of times, and with such manifest advantage to myself and satisfaction to my patients, that I think a word upon the subject may be not unacceptable to the Society. The surface sensitiveness of the anterior urethra may be so deadened by injecting ten minims of this solution along the pendulous and into the prostatic urethra by means of a deep urethral syringe that manipulation by instruments is tolerated much better than where this agent has not been used. No appreciable effect is produced on the deep urethra, and only the surface sensitiveness seems to be blunted. Cutting or stretching strictures is still painful and irritability at the neck of the bladder not sensibly modified, yet a manifest advantage is obtained in the facility with which explorations may be made and cutting instruments inserted before the painful final incision is made. Meatotomy may be performed almost without pain in some cases, and in one instance I performed deep internal urethrotomy to the great delight of the patient, who had been cut in former years. He joined in applauding the new method.

Chancres and warts, I judge, may be rendered insensitive to caustic, although I have not yet personally proved the fact.

Small tumors may, however, be cut out from the skin, and subcutaneous tumors removed almost without pain.

My first case was that of a physician with a small syphilitic chancre on the dorsum of the penis. The lesion was less than two days old, but the party from whom it had been acquired had undoubted syphilis. No glands were involved and the doctor wished the sore to be removed. I injected four minims of the solution directly under the sore, washed the whole cutaneous surface in a two-and-one-half-per-cent bichloride of mercury solution, picked up the sore and a fair amount of surrounding integument with toothed forceps, and with one cut of a scissors curved on the flat removed the sore, and the entire thickness of the skin beneath and around it. I then arrested hemorrhage, tied a small vessel, and applied three points of catgut suture. The doctor looked on smiling, and declared that although he could feel pressure he experienced not the slightest pain during all the manipulations.

My next case was the removal of a small epithelioma from the margin of the anus. I injected ten minims of the solution, five on each side of the ulcer, stretched the sphincter to a circumference of six inches with a three-bladed dilating speculum, and removed the growth. The stretching caused considerable pain, the cutting little or none, according to the patient's statement.

I have also removed warts, moles, and lipoma from physicians and patients with a uniform testimony that the pain was not worth mentioning. I have relieved mild anal pruritus at once by the application of the six-per-cent oleate, although the effect was quite temporary. The possible advantages of this application endermically or hypodermically need only be alluded to be appreciated.

What could be more agreeable, should it prove effective, as I believe it will, than to inject ten or more minims between the folds of the prepuce, and then cut away the prepuce and its injected fluid, and apply the sutures after circumcision without pain?

In cutting out lipomata, fibromata, wens, warts, and the like; in scraping, cauterizing, electrolyzing the skin; in tenotomy; possibly in removing inflamed glands and opening abscesses, in epilation and many similar processes it seems to me possible that a great future is open to this remedy.

What it will do when injected subcutaneously for superficial neuralgia and intense pruritus (scrotal for example) I have yet to learn.

No evil effects, local or general, follow the injection. A feeling of mild pleasurable excitement is experienced temporarily by some patients.

In the discussion which followed, Dr. Jackson narrated the case of a woman who came to him to have epilation performed, whose skin was so sensitive, when he began treatment on the 22d inst., that the slightest touch, when nine cells were used, would cause intense pain. He then applied a four-per-cent solution of muriate of cocaine in oleic acid over the left side of the lip and chin, and when the needle was inserted, there was only a little smarting of the part. To test the efficacy of the application, the needle was inserted on the right side, where the cocaine had not been applied, and intense pain followed.

DR. MORROW said that he had not had much experience in the use of the drug. He had used a four-per-cent solution on his own person, and so far as the abolition of sensibility was concerned, there was no marked effect. He had used the drug with marked benefit in cases of acute coryza. At the last meeting of the Medical and Surgical Society, Dr. Agnew was very explicit in his statements, and it was the universal opinion that in order to have any marked benefit result, it was necessary that the fluid should reach the papillæ. Dr. Morrow thought that in the form of the oleate, the cocaine would have a greater penetrating effect.

DR. SHERWELL had no personal experience in the use of the drug. There was a series of cases which Dr. Keyes had not mentioned, where he thought it would be useful; he referred to the operation for cure of painful fissures of the rectum: in such cases, he believed that pencilling with a solution of muriate of cocaine would lessen the sensibility during the operation of stretching or cutting the parts.

DR. STURGIS said that he had used a two-per-cent solution of American muriate of cocaine in passing sounds, but was not satisfied that it did any good. He injected twenty minims of the solution into the anterior portion of the canal. He thought that the subcutaneous injection would be attended with more certain results.

DR. KEYES, in concluding, said that thus far he had found that only the surface sensibility was modified. In cases of sensitive urethras he had passed sounds without pain, having previously applied the drug. In stricture, the passing of the instrument was not felt, but when the stricture was about to be stretched there was pain. Dr. Taylor had informed him that he had applied the muriate of cocaine to the prepuce, and had performed circumcision without pain. He had used the drug on some of the students in his class with the effect of diminishing the cutaneous sensibility.

Selections.

SYPHILITIC AFFECTIONS OF THE JOINTS, TENDONS, TENDON-SHEATHS, AND BURSÆ MUCOSÆ.

THE fact that lesions of the joints may be occasioned by syphilis has been recognized ever since this disease began to be accurately studied, *i. e.*, from the latter half of the fifteenth century. Observers in general, commencing with Peter Martyr, in 1488, and ending with Louvrier, in 1809, seem to have entertained no doubt upon the subject. Yet it is remarkable that the great authority of Hunter was directly opposed to the prevailing view. He says: "I do not recollect ever to have observed an instance in which syphilis has affected the joints, although many rheumatic disorders of those parts, which were cured by mercury, have, on this account, been regarded as venereal." Babington, Hunter's pupil and the editor of his works, commenting upon this passage, remarks that the judgment it embodies is too unqualified, and many succeeding writers have concurred in this opinion. A few, however, and those of

no mean repute, have contended that, although disorders of the joints do unquestionably arise during the course of specific disease, they may be referred to other causes than the syphilitic diathesis. Thus Colles (1839) attributes them to the mercurial cachexia, while by Ricord (1848) they were connected with rachitis, scrofula, and gout. For the earliest accurate account of syphilitic diseases of the joints we are indebted to Richet (1853), who, with other French investigators of our subject, opened up the path, in which they have since been followed by the Germans.

Taylor, of New York (1871) describes the chronic inflammatory and gummy affections of the finger joints, their tendons, and the sheaths of the latter, as accompaniments of dactylitis syphilitica, and cites two cases of tertiary synovitis. E. L. Keyes (1876) was the first to give a detailed account of syphilitic disorders of the bursæ mucosæ, dividing them into tertiary and secondary forms.

Among the latest writers, H. and M. Zeissl, in their "*Lehrbuch d. Syphilis*," 1882, speak with much reservation concerning specific lesions of the joints, and incline strongly towards Ricord's doctrine as above-mentioned. Krowczynski (1883), on the other hand, coincides with the French authorities, who regard the arthralgia, the subacute arthritis, and the hydrarthrosis, as forms of syphilitic joint disease. The rare occurrence of gummata around the joints he explains as due to the slight vascularity and the rigidity of those parts.

The *pathological anatomy* of the disorders we are considering has never yet been fully explored. The first recorded autopsy on a syphilitic subject in whom they existed was made by Coulson in 1853. Méricamp, in 1882, published an interesting case which may serve as a sample of the whole number: A woman in whom the initial symptoms of syphilis appeared in 1856, suffered, in 1859, from a swelling of the elbow, which, after returning several times, yielded at last to the action of the potassic iodide. In 1874, swellings appeared on the left knee and left elbow, caused by exostoses; also many similar growths on various bony parts. After her death, in February, 1882, the following changes were found to have taken place: Excepting some superficial erosions of the cartilage, the constituent portions of the joint were intact; the shaft of the femur was doubled in size by stalactitic exostoses; beneath the articular cartilage was a gelatinous deposit of a gold-yellow color, whose gummy nature was clearly revealed by the microscope. The left elbow joint was similarly affected.

Post-mortem examinations have taught us but little concerning syphilitic disorders of the tendons, and nothing whatever as to those of the bursæ mucosæ.

ETIOLOGY.—Under this head, in view of the fact that so little is known respecting syphilitic disorders of the joints, and that their very existence has been denied by prominent authorities, the following question claims our first consideration, viz., *Can simple uncomplicated syphilis, without the co-operation of other causes, suffice for the production of articular lesions?* Our answer is decidedly in the affirmative, for reasons which we now proceed to detail.

It has been shown by Virchow that syphilitic affections must be divided into two distinct classes. The first of these comprehends those merely inflammatory processes which run a more or less rapid course, and exhibit nothing of a specific nature either in their symptoms or in their underlying pathological conditions, while under the second are included all forms properly termed specific as being dependent in their origin and development upon that morbid project peculiar to constitutional syphilis, the gumma. We can only be positively certain, therefore, that an individual organ or organic system is affected with syphilis when we

know that it has suffered those gummy alterations which are characteristic of that disease, and the same test must be applied in order to determine the syphilitic nature of any merely inflammatory changes which it may have undergone. The correctness of this position has been demonstrated by post-mortem examinations. But it would also be a very extraordinary circumstance for any constitutional disease, more especially for one of an infectious nature, *not* to attack the joints, as may be inferred from the complications which so often arise in the course of measles, scarlatina, variola, typhus, cerebro-spinal meningitis, dysentery, dengue, and glanders. Moreover, the history of a syphilitic joint-affection is distinguished from that of other articular diseases by many striking peculiarities. Thus, if we examine closely, we shall find, perhaps, in a case which at first might be taken for one of ordinary polyarticular rheumatism, that the bodily temperature rises and falls with singular abruptness; that there is a total absence of cardiac complications; that the affection remains seated in a single joint, and displays a tendency to linger; that it passes into chronic forms, and that the pain is comparatively trifling in day time, but greatly aggravated in the evening and at night. All of these characteristics are strongly marked in many cases of syphilitic joint-disease, which they serve to distinguish from other non-specific forms of acute and chronic arthritis. If, in a patient presenting these signs, we can detect the manifestations, whether late or early, of a syphilitic diathesis, we shall be fully justified in referring his arthritic complaints to a specific origin, especially when, in addition, we are able to exclude (or, at least, are unable to discern) the operation of other causes. One important indication still remains to be mentioned. When confronted by an otherwise inscrutable ailment, we are wont to draw conclusions respecting its etiology from the results of treatment, and particularly as regards those widely-differing forms which may be attributed to syphilis must this last procedure oftentimes constitute our last resort. Nor can it rightly be called an unsafe one. It is a well-known peculiarity of syphilitic diseases in general that they show little or no tendency to disappear spontaneously, or in consequence of a merely symptomatic treatment, while, on the other hand, specific medication, as a rule, is speedily and remarkably successful. This observation applies with equal force to disorders of the joints. Just as we unhesitatingly pronounce a paralysis of the motor oculi, an iritis or a choroiditis, a periorchitis, etc., when occurring in a syphilitic subject, to be a symptom of syphilis, if, after defying other remedies, it yields to anti-syphilitic agents, even so must we judge, under like circumstances, in the case of an arthritis. Finally, the fact, established by post-mortem examinations, that articular lesions may accompany hereditary syphilis, supplies further evidence in favor of our proposition that they may likewise proceed from the acquired infection.

But little attention has been paid to syphilitic disorders of the tendons, tendon-sheaths, and bursæ mucosæ. The fact of their occurrence, however, is beyond dispute.

COURSE AND VARIETIES.—Syphilitic affections of the joints are much more common than is generally supposed. Only a portion of them lead to alterations in growth and nutrition; the remainder take on the form of functional disturbances, viz.:

I. Arthralgia.—Pains in the joints are a frequent concomitant of constitutional syphilis. They make their entry at a very early stage, often forming one of the most prominent symptoms of the eruptive period, and subsequently preceding and accompanying every fresh outbreak of the disease, without ceasing their attacks, even during the intervals of complete remission in other respects.

They usually affect only the large articulations—those of the knee, hip, and shoulder, though occasionally felt in the finger joints. Sometimes they are described as of a boring or rending character, and are especially aggravated at night, causing little trouble during day-time; in other cases, a sort of stiffness in the joints is complained of, chiefly on moving them after resting a good while. Thus, on first rising in the morning, the patient can scarcely get about, owing to pain which seems caused by the ends of the joints rubbing against each other, “as if all the oil were out of them.” As movement proceeds, it becomes less irksome, and during the rest of the day the pain is experienced only after repose, or else ceases altogether, to return with renewed intensity on the following morning. In many cases of this sort, friction and crepitation of the joint are objectively apparent, leading to the conclusion that the ailment is not simply neurotic, but is due in part to slight exudative processes.

Of more serious import than these purely functional disturbance are those articular affections which depend upon altered states of nutrition, and are capable of pathological demonstration. Following Virchow's classification, we will divide them into simple, exudative, irritative, and specific gummy varieties.

II. *Simple Inflammations of the Joints*.—These run their course under the guise of acute and chronic serous synovitis. The latter are divided, according as the synovial affection is primary or consecutive, into a *protopathic* and a *deuteropathic* variety, each of which includes several subordinate forms.

1. Among *protopathic synovitis* we enumerate:

(a) *Acute Polyarticular Synovitis*.—This bears a strong resemblance to polyarticular rheumatism. It is marked by a very painful swelling, usually of the larger joints, several of which are attacked simultaneously or in quick succession, and is attended with considerable fever. It is distinguished from acute rheumatism by its strikingly remittent fever curve, but still more by the fact that salicylic acid, which is the specific against polyarticular rheumatism, exerts no influence upon this syphilitic inflammation. Acute polyarticular synovitis, on the other hand, is promptly subdued by the specific action of potassic iodide. When this latter complaint is unseasonably or injudiciously managed, it shows little tendency to subside; in this case, as a rule, the symptoms merely become less acute, pain and fever diminishing, while the changes characteristic of chronic hypertrophic synovitis are developed in the joint.

(b) *Acute Monoarticular Synovitis*.—Rapid swelling of a single large joint, to which it is confined throughout the duration of the complaint, attended with inflammatory symptoms, and generally moderate fever. Here, also, salicylic acid is without effect, while potassic iodide very soon removes the trouble. Under improper treatment the inflammation subsides, but the swelling remains, and this form, like the preceding, passes into

(c) *Chronic Hypertrophic Synovitis; Hydrarthrosis*.—This makes its appearance, sometimes as an outcome of (a) or (b), sometimes as a primary affection, in the shape of a painless swelling of the joint, which gradually advances, unless opposed by antisiphilitic remedies. The pathologico-anatomical changes which it occasions have been clearly shown to consist in chronic hyperplastic inflammations of the capsule, with proliferation and the production of villi; erosion and destruction of the cartilage, causing deformity of the articular extremities; and, finally, in ankylosis.

2. All these analogous varieties of synovitis are also developed *deuteropathically*, by the extension of syphilitic disease from neighboring parts, most frequently the bones. In this case, also, we distinguish two forms, the acute and

the chronic, which depend respectively upon the acute or chronic nature of the primary affection.

An opinion which has recently been advocated by some prominent authorities, *i. e.*, that in *hereditary syphilis only the shafts of the bones are invaded, in acquired syphilis only their epiphyses*, I must pronounce to be untenable, whether clinically or anatomically regarded.

III. *Gummy Arthritides*.—In this variety the gummata are not known to be developed primarily from the synovial membrane or the capsule, and afterwards to fill up the cavity of the joints by their proliferations. They form, in the first place, upon and around the articular ligaments, and in the loose cellular and adipose tissues enveloping the capsule, and are accompanied by chronic synovitis and serous effusion into the cavity of the joint, and proliferation of the synovial membrane; the gummy process invading the capsule and penetrating into the interior of the joint only at a later period. All these processes take place chronically; the symptoms varying in their development and combinations, according as the gummy formation or the serous synovitis takes the leading part. Thus, in the former case, we may have a chronic pannous arthritis, with production of nodes which can be felt within the capsule, or outside of it in one or the other articular ligament, while, in the latter, there occurs a painless, tense, generally uneven swelling of the joint, the contents of whose cavity are only slightly increased. The breaking through of the gumma, inwardly and outwardly, may lead to pyarthros, by laying open the articular cavity.

IV. *Anchylosis*.—The chronic hyperplastic and the gummy arthritis have this in common, that both are accompanied by a new formation of connective tissue. In this way the capsule and the articular ligaments are thickened, and new connective-tissue cords are formed, which extend from one extremity of the joint to the other. As time proceeds, these cords retract and become more and more rigid, until motion of the part is impeded, or rendered completely impossible, by the establishment of a fibrous anchylosis. Bony anchylosis, to a greater or less degree, may arise, in cases of periostitis, from osteophytes on the epiphyses, with deformity of the articular extremities; or, finally, ulcers of the joint may result in cicatricial contractions leading to anchylosis spuria.

Among the articulations, that of the knee is by far the most frequent seat of syphilis; next in order come the elbow, shoulder, and hip-joints, while the wrist is very rarely affected.

Syphilis of the Tendons and Tendon-sheaths undoubtedly occurs; and here also we distinguish two forms, the irritative and the gummy.

1. The *irritative form* may show itself as:

(a) *Tendovaginitis*, in which increased effusion into the sheaths of the tendons is followed by tense and painful red swellings along the course of the latter, together with febrile symptoms. Motion is impeded and often quite impossible; it is frequently accompanied by friction, which is caused by the mutual contact of coagula adhering to the tendons and their sheaths, and is apparent to both touch and hearing. In other cases, the complaint is chronic, and takes the form of

(b) *Dropsy of the Tendon-sheaths*.—A cylindrical or spindle-shaped swelling following the course of the tendons. It is quite painless, is covered with normal skin, fluctuating, and often crepitates plainly on palpation.

The former of these processes terminates in recovery, or becomes chronic. The latter has little tendency to cease spontaneously, but causes thickening of the tendon-sheaths, steady increase of their contents, and hence difficulty in movement. Both varieties are more frequently met with in females than in males;

the parts most liable to attack are first the fingers and toes, next the region of the biceps and peroneus, and lastly the knee-joint.

Syphilitic Diseases of the Bursæ Mucosæ are less known than any others included in our subject. Keyes has only observed them in the gummy forms. Recognizing, according to our previous classification, an irritative variety as well, we are able to adduce from our clinical records a fine example of

(a) *Acute Bursitis*.—Developed as a painful, plainly fluctuating swelling, interfering with every movement, but not communicating with the joint, and which yielded to potassic iodide.

(b) Also, one of præpatellar *Gummy Bursitis*. This presented a painless, tense tumor, either originating in the bursa itself, or seizing upon the latter from an adjacent part, which, after lasting several months, finally softened at its centre ; from thence the infiltration extended to the outer integument, which first turned livid and thin, then broke, and disclosed a deep ulcer with solid contents.

This affection is more frequent in women than in men, and usually occurs in the knee-joint.

PERIOD OF APPEARANCE.—DIAGNOSIS.—No fixed rule is observed by the diseases we are considering as regards the period of their appearance during the course of constitutional syphilis. This, however, is certain : that, from the date of the earliest specific eruption, until the last lurking trace of the contagion has been banished from his system, no syphilitic subject is secure against their occurrence. Since, in general, the irritative forms of syphilis are signs that the disease is still recent and in its acute stage, we are authorized in ranking the corresponding varieties of specific arthritis, etc., before the gummy lesions, in the order of their development. They may be said to make their earliest appearance within the first two or three years after infection. They become less acute the longer the constitutional disease continues, so that at the end of the secondary stage, or the beginning of the tertiary, the subacute and chronic forms are to be looked for in their stead, such as dropsy of the joints and tendon-sheaths. Finally, the gummy varieties are manifestations of syphilis rendered inveterate by the lapse of years.

As to the question of diagnosis, characteristic symptoms and morbid appearances can no more be assigned to the irritative forms of these affections of the joints, tendons, and bursæ mucosæ, than to a hepatitis or nephritis diffusa syphilitica. On the other hand, many of their purely syphilitic varieties present peculiar features, among which the thermometric variations, and the absence of complications on the side of the serous membranes, are the most significant. In a general way, it may be said that these syphilitic forms rarely attain to the intensity and degree of acuteness which mark the analogous non-specific rheumatic and traumatic ailments. Their diagnosis must rest upon the fact of their resisting all except specific modes of treatment, while responding promptly to the latter; upon the proof of their co-existence with the constitutional disease, and the exclusion of other causes. For the gummy varieties, we seek the evidence afforded by their specific morbid product, the gumma ; or, failing this, must arrive at our judgment through a consideration of probabilities, as well as “*ex juvantibus*” and “*per exclusionem*.” The chronic character of these forms is suggestive of a diathetic influence, and here syphilis, scrofula, and tuberculosis should chiefly be taken into account.

Prognosis and Treatment.—Since the irritative forms we are now dealing with manifest no special characteristics, but display the same simply inflammatory symptoms as affections of a different origin, while still the fact is beyond dispute

that they may be produced by syphilis, it is incumbent upon the physician to bear the latter disease in mind when investigating their etiology, and should he suspect its existence, to adopt antisymphilitic measures. Especially is this his duty if he has previously tried every other kind of treatment without avail. As in other syphilitic cases, he will place his chief reliance upon mercury and iodine. In specific affections of the joints, etc., we generally prefer the iodine preparations to the simple mercury. Iodine, as the best anodyne and febrifuge in syphilitic complaints, is especially appropriate when there is great pain accompanied by fever. A liberal administration of potassic iodide—3.0 to 6.0 grm. pro die—will often cut short these latter symptoms at once, and if followed up by smaller doses—0.5 to 2.0 pro die—will soon put an end to the swelling and infiltration. Management of the chronic forms is a more difficult matter. Here, besides the energetic employment of mercury and iodine, resort must be had to more remote auxiliaries—baths of sulphur, iodine, and “sool”—in order to complete the cure. If, however, the mischief is so far advanced that connective tissue has formed in large quantities, while the cartilage is in great part worn away, and the articular capsule, the tendon-sheaths, and the walls of the bursæ mucosæ are very much thickened, lined with villi, or perhaps shrunk, then no satisfactory results can be expected from the most judicious treatment, but only a cessation of the morbid process, or, at best, a slight improvement. Prognosis is more favorable in the gummy varieties, which, so long as there are no disorganization and no cicatricial growths, may heal completely under specific medication; though, after cicatrices and new connective tissue have formed to any extent, these too must be regarded as hopeless.—ERNST FINGER, *Wiener Med. Wochenschrift*, 1884, Nos. 28, 29, 30, 31, 32, 33, 34.

INGROWING TOE-NAIL.

DEFINITION.—A chronic, painful, traumatic inflammation of the tissues at the margin of a toe-nail. The inflammation is usually attended with the formation of granulations and with suppuration, and it is nearly always of the great toe-nail, usually on its outer side. There is a form of so-called in-growing toe-nail which is not attended with suppuration, but is dependent on an accumulation of epidermic scales between the nail and the flesh; and very rarely, the disease may exist in one or other of the lesser toes.

CAUSATION.—In civilized countries, we must always recognize the element of compression, or at least prevention of expansion inside a boot. It is perfectly conceivable that the condition might exist in individuals who never wear boots, but for practical purposes we must take the boots for granted. They are a constant concomitant, and if not a prime, are probably a contributing cause. It is, however, a cause which we cannot remove. We must treat the toe inside the boots. Indeed, the patient will probably have removed the cause long before we see him. Looking beyond the boots, we find that the causes may be arranged as intrinsic, or depending on peculiarities in the toe or nail, and extrinsic, or dependent on the direction of the toes or the condition of outlying structures in the foot.

I. INTRINSIC, *i. e.*, in the nail, or in the surrounding tissues, or in both.

1. *In the nail.* In some people, the nails in the fingers and toes—and I have noticed that the peculiarity is usually coincident—are convex or arched, and dip deeply into the surrounding flesh. In such cases, in paring the nail of the great toe, it is difficult to carry the knife or scissors completely round, and thus there is frequently left behind a small spicule or pointed piece, which readily insinu-

ates itself into the neighboring flesh. Matters are sometimes made worse by pulling at this piece, "tearing it to the quick." The flesh swells and conceals this small piece of outlying nail; it is overlooked, sets up irritation, and the condition is developed.

2. *In the flesh.* Some people have a redundance of flesh in their toes, and their fingers as well. In these the flesh overlaps the nail, and in the foot the confinement of the boot, added to the soddening perspiration under the overlapping flesh, readily starts the condition. Once started it continues, and suppuration along the margin of such a toe may continue for years. Fortunately, it is the least painful, and most easily treated of all the varieties.

3. *In both nail and flesh.* The existence of both the above conditions—an arched toe-nail and an excess of soft tissue—will frequently be found associated with the malady. Alone or in combination with extrinsic causes, this double condition, with the mere wearing of boots, is almost enough to cause this complaint. In this case also it is not likely to be severe.

II. **EXTRINSIC**, or from causes lying outside the nail and its surrounding tissues.

1. *Flattening of the arch of the foot.* Flat-foot, in varying degrees, I believe to be the most important cause of in-growing toe-nail, and all the more so that the ordinary modes of treatment are futile to cure it. It acts in this way through the attempt of the point of the great toe to become the anterior pillar of the arch of the foot—the natural support of the latter, viz., the pad at the root of the toes, particularly of the great toe, not being available on account of relaxation and perhaps painfulness of the plantar ligaments. But constant use of the toe in this wise induces hypertrophy of its tissues and consequent overlapping of the toe-nail. By easily understood stages this hypertrophy becomes irritation, inflammation, and suppuration where the flesh is crowded over the edges of the nail, and we thus get the condition fully developed.

It is simple flat-foot, *pes planus*, and not splay-foot, or *pes valgus*, which is most likely to start the mischief. And it has seemed to me that not the worst cases of flat-foot—those which require operation—but the moderate cases, which require no special treatment for the flattening, are chiefly associated with in-growing nail.

2. *Eversion of the great toe.* The production of this condition, I believe, will be most frequently found to depend either on a habit of walking with the limb much rotated outwards, or on a congenital deflection of the toe itself. This too great proximity may merge into a passing beyond, and then we have the second toe, perhaps with the third, overriding the great toe, and evidently causing the complaint.

3. *Inversion of the lesser toes.* In this case the same result as the preceding is produced by a deviation inwards of the second and third toes. How it is produced I do not know.

TREATMENT.—I. 1. Where the cause is intrinsic and resident in the nail alone, it may usually be remedied by careful attention to the "toilet" of the nail, using a knife rather than a scissors, and cutting from behind forwards obliquely, so as to give the nail a pointed shape. By this means, the leaving behind of sharp portions at the margin which are insinuated into the flesh is rendered less likely. If the granulations are exuberant, I would recommend the application of a crystal or two of chromic acid, which leaves a hard, dry scab, under which the sore heals kindly. Careful trimming of the nail will usually ward off the complaint in future.

2. Where the cause lies in a superabundance of flesh in the toe, a condition which is usually accompanied with thin, tender skin, which perspires and chafes readily, I believe the best plan to be: First, the application of chromic acid, if necessary, and thereafter pressure, either by strapping or by elastic. Every night the affected toe is to be surrounded tightly from the tip upwards by thin strips of adhesive plaster taken out of boiling water. This may be removed in the morning and replaced by an india-rubber cap, such as is worn over a sore finger during a *post-mortem* examination. The toe is thus rendered and kept anæmic by compression; congestion is removed, and the tissues get more firm and resisting in the course of a few months.

In such cases, I have sometimes noticed that the feet perspire freely, and then the wearing of fine worsted socks, the nightly use of a foot-bath, into which enough sulphuric acid has been poured to make the skin tingle, and sprinkling some powdered boracic acid over the foot every morning will expedite the cure.

3. When there is a combination of malformed nail and overgrowth of flesh, a judicious combination of the methods just described will probably effect a cure. Here, if anywhere, a scraping of the nail, making it thin and yielding, ought to do good; but I am doubtful of the utility of this procedure. The nail is too firmly bound down to the matrix to yield much to lateral pressure, and constant scraping, I think, has a tendency to develop an irritative hypertrophy of the nail itself. If all these or similar plans fail, there is nothing for it but removal of the nail in the manner to be described presently.

II.—1. Of intrinsic cases by far the most important is flattening of the arch of the foot, and unless this cause is clearly recognized and successfully met, our treatment will almost certainly fail. To restore the arch of the foot, probably the most scientific treatment would be to make the patient recline on his back for some weeks, and permit the stretched plantar ligaments to regain their tone. In actual practice it will be found a very efficient plan to wear a small pad of several thicknesses of chamois leather or flannel under the ball of the great toe. This pad may be put on every morning, and retained in position by a collar of thread or elastic carried round the root of the great toe. The toe, thus elevated beyond the reach of harm and relieved from its illegitimate labor, soon regains its normal condition. After a few months the pad may be gradually given up, and with care, the condition need not recur.

2. When the cause is eversion of the great toe, from whatever cause arising, the treatment is by no means easy. What I have found most satisfactory is a pad between the great and second toes, stopping short of the sore part. The pad may be constructed of several layers of flannel or chamois, and is kept in position by two collars round the root of the great and second toes respectfully.

3. I have seen only three cases of the second and third toes overlapping the first, and causing ingrowing of its nail. In these the condition was easily remedied by wearing a double band of tape, so arranged as to keep the two offending toes turned outwards and pushed downwards. The tape was fixed in a loop round the fourth toe, passing double over the second and third toes, and then surrounded the great toe. The little apparatus is easily made by the patient.

So much for the scientific treatment of the complaint. But there is a class of cases, chiefly among hospital patients, in which imperfect intelligence and want of cleanliness nullify our efforts. Such patients have usually flat-foot, but they want to get well at once and permanently, and the endless worry of the morning pad is beyond their endurance. For all these, I remove the matrix as well as the nail, and scrape the periosteum off the bone. The operation is certain to cure

permanently every case of the disease; it is a simple one, and by the exercise of a little dexterity, may be done on both feet while the patient is under the influence of nitrous oxide gas. The knife grazing the bone is carried rapidly round the flesh on the right side of the nail, and by a change of the same movement, passes under the nail down to the bone, and lifts away nail, matrix, and suppurating flesh. A piece of boracic lint is wrapped tightly round the toe, and need not be removed for a week. In the mean time the patient may get about. At the end of a week the sore will be smaller than the nail removed, for the healthy tissues have been pressed inwards over the sore. In three weeks the wound is cicatrized over, and most likely in a few weeks more a stunted nail is developed, like that usually seen on the fifth toe, from which no trouble ever arises.

If the patient is not anxious to have a handsome nail on his toe, I never hesitate to let him have this mode of cure. The loss of a toe-nail, at its best, can never be a great one; and when it is ingrowing its loss is a gain.

I confidently recommend the procedure as far preferable to mere avulsion of the toe-nail, a plan of treatment which, in my opinion, ought to be abolished from surgery.—J. GREIG SMITH, *Bristol Medico-Chirurgical Journal*, June, 1884.

HYPERIDROSIS AND BROMIDROSIS.

HYPERIDROSIS is an affection in which there is an abnormal functional activity of the sweat-glands. Many, especially corpulent people, who are otherwise in apparently perfect health, sweat excessively without apparent provocation, and are annoyed thereby to a greater or less degree, particularly in warm weather. The affection may occur in an acute form, and subside in a short time, but generally it is extremely chronic.

Hyperidrosis may be general or local in its manifestation.

Occurring over the whole surface of the body, it is not usually severe, but when limited to certain parts, it is much more noticeable, and constitutes a not uncommon and an extremely disagreeable affection. The palms, soles, and axillæ are the parts which are most apt to be the seat of the trouble, but the face and the genital regital region are not infrequently affected.

In rare cases, hyperidrosis occurs in a unilateral form. One side of the head, or one of the extremities, or even one-half of the entire body may be bathed in perspiration, while the opposite side retains its natural condition.

Hyperidrosis of the hands is not only annoying to the patient himself, but to those whom the social custom requires him to greet with a shake of the hand. Often, also, the affection prevents the sufferer from following any occupation involving the handling of fine textures.

Hyperidrosis of the feet is often associated with a similar condition of the hands, but either may exist alone. When the feet are the seat of the affection, the stockings, however frequently changed, are kept moistened by the secretion, and even the leather covering of the feet becomes soaked in time. A disagreeable odor is usually occasioned by the chemical change which the secretion undergoes.

Treatment.—The predisposing causes of hyperidrosis should be diligently sought for in every case, and removed if possible. Nervous derangement and an impaired circulation are frequently underlying conditions which demand the most careful hygienic treatment. Among the drugs which have been recommended as capable of producing beneficial results in this affection are atropia and ergot. Small doses of jaborandi have also been employed with good effect in

both local and general hyperidrosis. As it is impossible in many cases to determine the precise cause of the disorder, we are generally forced to depend largely upon external applications, many of which give immediate relief, and in time subdue the excessive secretion. When the sweating is general, baths containing sea salt or carbolic acid may be employed, or portions of the body rubbed successively with a soft sponge dipped in the following lotion:

Sulphate of quinine..... 5 parts.
Alcohol.....to 500 “

M.

In hyperidrosis of the axilla or genital region, the skin may be bathed with a strong solution of tannin or alum, and after careful drying, the following powder dusted over the surface:

Salicylic acid.... 3 parts.
Starch ... 10 “
Talc powderto 100 “

M.

For the hands and feet, a similar plan of treatment is useful. Another excellent remedy is the subnitrate of bismuth, rubbed well into the skin after bathing, or dusted over the inside of the gloves or stockings. Hebra advised a plan of treatment which, if properly carried out, usually affords immunity from the annoying secretion for a considerable time, if it does not effect a cure. This plan consists in spreading diachylon ointment upon pieces of linen, with which the fingers and toes, as well as the rest of the hands and feet, are carefully enveloped. This dressing is to be re-applied twice daily for a week or two, the hands not being washed in the mean time. The application causes an exfoliation of the epidermis, leaving the skin soft and comparatively dry.

BROMIDROSIS is an affection in which the perspiration is characterized by a peculiar and usually an extremely disagreeable odor. The normal perspiration has always a slight odor, although this may not usually be perceptible to the average sense of smell. In disease, also, the perspiration is frequently changed in character, and various affections have been supposed by some to have each its distinct and characteristic odor. Certain persons, whose skin is perfectly free from disease, and whose general condition is good, exhale from their bodies a peculiar odor, which seems to be natural to them.

In bromidrosis, the secretion may exist in normal amount, or it may be in excess. The latter is commonly the case upon the feet and in the axillæ, in which case we have simply hyperidrosis with a foetid odor. This odor may not be due to any change in the composition of the perspiratory secretion, but usually results largely from the decomposition of the sweat which has soaked into the clothing of the part. In bromidrosis of the feet, even the shoes may become saturated with the foul secretion.

The peculiar odor may also be due, in great part, to a peculiar secretion of the sebaceous glands, which becomes mingled with the perspiration. As the foetid secretion of bromidrosis is more irritating to the skin than a simple excess of perspiration, we find in this disease a marked tendency for the skin, especially of the feet, to become macerated and tender. Upon the soles the epidermis is always sodden, and often peels off in large masses, leaving an inflamed and often eczematous condition, through which locomotion is often seriously impaired.

Treatment.—The general treatment of bromidrosis is substantially the same as that of hyperidrosis, since whatever lessens the amount of the secretion, tends

to diminish the unpleasant odor. The more severe forms of foetid sweating are often checked by the adoption of such measures as promote the general health of the person affected. As palliatives, lotions, and dusting-powders of an antiseptic character have been found most useful in bromidrosis, especially when the disease involves the feet, as it is most apt to do.

For bathing the skin, a one-per-cent solution (five grains to the ounce) of chloral or permanganate of potash is both cleanly and beneficial. It should be applied with as little friction as possible, and allowed to dry upon the skin, or the excess of moisture may be removed by the pressure of a soft warm cloth. Ainsworth recommends the application of the following powder:

Dried alum.....	45 parts.
Salicylic acid.....	5 “

M.

Thin, of London, recommends the use of boric acid. The stockings should be changed twice daily, and the stocking-feet placed for some hours in a jar containing a saturated solution of boric acid. They are then dried, and may be worn again, the odor having disappeared.

Cork soles are to be worn during the day and soaked over night, like the stocking-foot, in a jar of boric acid.—GEORGE HENRY FOX, *Phil. Med. Times*, Aug. 23, 1884.

ETIOLOGY OF TRICORRHEXIS NODOSA.

ABOUT three years ago, I observed that numerous otherwise healthy hairs in the middle portion of both my whiskers were irregularly beset with minute whitish protuberances resembling the eggs of lice. These formations were only met with at some distance from the skin; wherever they occurred the hairs were slightly bent and cracked, or, in many instances, were broken off and ended in small whitish bulbs. In brief, the abnormal appearances were precisely those of the often-described tricorrhexis nodosa, and microscopic examination revealed the tissue-changes already supposed to characterize that disease. Evidence derived from the latter source led me to a conception respecting the origin of these phenomena, whose correctness is confirmed by the fact that I was enabled to prevent their reappearance on the after-growing hairs in the same situation. In a patient who sought treatment for a different complaint, I subsequently discovered the same capillary alteration, and was again successful in removing it. My practice, since then, having been of a more general character, I have no other case to report of this probably not infrequent affection. Nevertheless, I feel myself in a condition to affirm that habitual rough handling of the beard—as, for instance, hard friction with the towel after washing—will suffice to cause tricorrhexis nodosa in many persons. I have reproduced it purposely in one of my own whiskers, where I exhibited it to several colleagues, together with microscopical preparations from the same, which completely corresponded with those obtained by previous observers. My reasons for regarding mechanical ill-usage as the sole cause of this abnormality may be arranged under the following heads:

I. *Anatomy of the parts.* Outside of the characteristic prominences, the hairs are found to be quite normal in every respect. The microscope shows that at each one of the affected points the capillary substance has become fibrillated or unravelled, so that the opposing extremities of the two portions into which the hair-shaft is there divided, fit into each other, as a couple of broom-heads may be made to do. This condition, it has been hitherto assumed, is brought about

by some force acting from within outwards, but the fact that it can be produced at will in the case of any and every individual whose beard, like my own, is coarse and somewhat bristly, goes far to show that its cause is wholly external.

II. *Locality of the nodes.* Excepting in a solitary instance, tricorrhexis nodosa has hitherto been observed only in the medullated hairs of the beard. It is easy to understand why the formation of the nodes is more likely to occur, from mechanical ill-usage, on such hairs as inclose a medullary tube, than on more delicate, and therefore more flexible hairs which have no such contents. To the former class belong the hairs of the beard, which, moreover, are comparatively thick and brittle—two other conditions which also favor the splitting up of their fibres, and the production of spindle-shaped or rounded prominences.

It is further to be noted that the section of beard chiefly liable to this disfigurement is that on which friction produces most effect, owing to the resistance offered by the underlying maxilla.

In some cases the disorder is seated on the moustache.

III. *The insufficiency of previous explanations.* By Wilks the phenomena in question were regarded as due to a fungoid growth; Schwimmer attributed them to disturbed nutrition of the hairs; Beigel, to the presence of air-vesicles; Eichhorst, to "hyperplastic" processes within the medullary cells, leading, in the first place, to fatty infiltration of the latter, and secondly to fibrillation of the cortical substance. In my opinion, it is this fibrillation which is the primary occurrence. It is readily conceivable that the fatty and almost fluid contents of the medullary cells should frequently be squeezed out by the rubbing and twisting to which the hairs are subjected, and, being pushed, in the form of lumps or drops, against the decorticated places in the latter, should give rise, at such points, to spindle-shaped swellings of the medullary substance. Conversely, also, the fatty contents are driven from the region of the protuberances into adjoining parts. The fat-granules, moreover, after escaping from the central channel, are here and there pressed against the cortex, and penetrate through the fibrillated portion of the latter, to the external surface of the hair.

IV. *The hitherto intractable character of the complaint* is easily accounted for, if we consider that it has been attempted to remove a disorder, originating in the manner just described, by the employment of friction (with spirituous fluids, irritating salts, etc.).—S. WOLFFBERG, *Deutsche Med. Wochenschrift*, July 31, 1884.

OLEATE OF COPPER; ITS EMPLOYMENT IN PARASITIC DISEASE OF THE SKIN.

TREATMENT of diseases of the skin due to the presence of a vegetable parasite has not heretofore yielded the most satisfactory results, owing chiefly to the lack of a drug or preparation which could be looked upon as a specific, or nearly such, that is, could be depended upon as capable of invariably effecting a cure. The oleate of copper, when *chemically pure*, would seem to be all that is required, and, in my experience, has answered every purpose most admirably, possessing none of the objectionable features alleged against it when manufactured from the formula contained in the United States Pharmacopœia. In the application of the improved oleate (which is practically of *full strength*) dilution is necessary, and this is easily accomplished by the addition of cosmolin, so that the varying strengths of *ung. cupri oleatis* may be readily encompassed.

The scope of usefulness of the remedy, so far as my observation goes, is confined to practically seven diseases, viz.: *tinea tonsurans*, *t. circinata*, *t. kerion*,

eczema marginatum—all caused by the same parasite; *t. sycois*, *t. versicolor*, and *t. favosa*—each due to a separate parasite. My plan of treatment is as follows: if affecting a hairy part, first of all cut off the hair close to the skin wherever a diseased patch shows itself, the clipped area extending at least one inch, and oftener one inch and a half, beyond the margin of the advancing lesion. Having done this, the parts are then anointed with oil, fluid cosmolin (petroleol), or glycerin, or a bread-and-milk-poultice is applied. This for the purpose of dislodging scales of crusts if any be present. For the same purpose, when very much scurf or actual dirt is accumulated upon the parts, as is not infrequently the case, especially in public practice, I occasionally direct the parts to be thoroughly scrubbed with castile soap and warm water. Then an ointment of the oleate of copper, of a strength suited to the severity of the case, is prescribed and ordered to be rubbed into the diseased patches, gently but thoroughly, so as to procure as complete and rapid absorptiou as possible. If an exposed part, as in the case of ringworm of the head, it may be lightly covered with some appropriate material, or left bare, as the judgment and exigencies of the case dictate. The process of iunction should be repeated at least twice daily, this being usually amply sufficient. Unless an accumulation of scab-like substance should appear, it is not necessary or even desirable that the part be washed except at infrequent intervals. The following prescription illustrates the average range of strength in which the ointment is most frequently employed:

R Cupri oleatis 3 i-vi.
 Ung. petrolei...q. s. ad 3 i.

M.

Between the two extremes above noted, I choose a strength which the judgment indicates as being best suited to the case. If the case be of a mild character, often seven or eight days suffice for a cure. If, however, it is severe, from ten days to three weeks, or, in exceptionally obstinate cases, even longer periods than this, may be required.

Some months ago, at my suggestion, some oleate of copper was prepared in the form of gelatin-plasters, which were used in a few dispensary cases. The effect was all that could be desired.

Up to January 1, 1884, no fewer than five hundred and twenty-three cases came under my observation. Eliminating the odd twenty-three cases, for purposes of convenience, a tabular analysis of the remainder exhibits the following as its more striking results:

Out of the total number, eighty-four cases occurred in private practice. Of these, about 86 per cent were caused by the *trichophyton tonsurans*. Of the four hundred and sixteen cases met with in public practice, no fewer than three hundred and eighty-nine, or about 93.5 per cent, were caused by the same agent—thus showing that of all the various forms of vegetable parasites, the *trichophyton tonsurans* is by far the most prevalent.

Epilation is rarely necessary in parasitic diseases where copper oleate is used. In favus, it must be confessed that the cure is retarded if epilation is not resorted to. This is the only disease of this nature in which the remedy has not produced a more rapid cure than other drugs. But I need not point out, as counterbalancing this, the preservation of partially good hairs and the suffering avoided; the facts are self-evident. Using the five hundred cases as a basis, I think better and quicker results, speaking in geueal terms, are obtainable by the copper treatment of the parasitic diseases than by any other plan. No better evidence of its

permanency is afforded than that every one of these cases was relieved *entirely*, not a single relapse having come to my knowledge.

In almost all cases of disease of the skin, be it parasitic or not, the patient is physically below par, and tonic treatment is imperatively called for. The proper supporting and reparative measures must vary, of course, with the exigencies of the case.

I have observed in a number of cases, probably not exceeding six or seven, a tendency to the formation of the so-called "blind" furuncles. In these instances the swellings developed after the application of the very strong ointment; but—and this is an interesting point—in many, if not all, the persons thus affected there existed a more or less well-marked tendency to a strumous diathesis. In consequence of this significant fact, the question has suggested itself to me whether the swellings would not have occurred with the application of any other remedy; if, indeed, they would not have presented themselves any way sooner or later through the aggravating influence of the morbid dermal state.—F. LE SIEUR WEIR, *N. Y. Med. Journ.*, August 30, 1884.

CUTANEOUS AFFECTIONS INDICATIVE OF THE HERPETIC DIATHESIS.

THE herpetic diseases constitute a class by themselves in dermatology. They are distinguished from all other cutaneous disorders by the most unmistakable signs. While the lesions of the syphilides and the scrofulides, even when the deepest seated and of the most serious character, are absolutely painless, and compatible with the normal exercise of all the vital functions, the slightest and most superficial manifestation of herpeticism may be accompanied by sufferings so excruciating as to result in positive danger—witness those severe forms of lichen, prurigo, and eczema in which the intolerable itching often deprives the patient of sleep and appetite, and drives him almost into a state of frenzy.

Yet, notwithstanding the extreme distress which they occasion, eruptions of this latter class are sometimes necessary to the preservation of the general health. Their abrupt suppression may give rise, by metastasis, to internal disorders of the most obstinate character, and which, in fact, only cease on a reappearance of the cutaneous symptoms. These affections (psoriasis, eczema, lichen, prurigo) may, in certain cases, be regarded as salutary critical processes, both cleansing and revulsive in their nature, and therefore indispensable for maintaining the balance of the system.

While syphilis, during its protracted stages, recedes farther and farther from the integument, and narrows more and more the extent of its lesions; herpeticism, on the contrary, becoming worse as time advances, goes on enlarging its hold upon the territory of the skin. Intermittent at first in its cutaneous manifestations, it establishes itself, later on, as a continuous and permanent affection; its initial lesions, starting as mere isolated points (psoriasis punctata, psoriasis guttata), finally overspread enormous tracts, which often comprehend the entire bodily surface (psoriasis diffusa, psoriasis inveterata, eczema universale).

Syphilis and herpeticism, then, are absolutely opposed to each other in their progressive development upon the skin.

The various painful sensations (itching, tickling, smarting, lancinating, pricking) which are connected with the herpetic eruptions, the general distribution of those eruptions, their symmetrical disappearance, their tendency to relapse, their long duration, the dangers involved in their metastasis, their transmissibility by descent, such are the leading characteristics of this class of

diseases, and such, also, are some of the evidences which affirm the existence of the herpetic diathesis.—GUIBOUT, *Gaz. des Hôp.*, Aug. 7, 1884.

Review.

HANDBOOK OF THE DIAGNOSIS AND TREATMENT OF SKIN DISEASES. By ARTHUR VAN HARLINGEN, M.D., Prof. of Diseases of the Skin in the Philadelphia Polyclinic, and College for Graduates, etc. With two colored plates. Philadelphia: P. Blakiston, Son & Co., 1884.

As Dr. Van Harlingen tells us in the preface, this handbook is designed to meet the wants of the general practitioner. He confines himself to the description, diagnosis, and treatment of skin affections, referring but briefly to their etiology, and leaving aside all consideration of their pathological anatomy as foreign to the scope and plan of his book. The arrangement of the different diseases in alphabetical order is well adapted to facilitate ready reference. Another concession to the "wants of the practitioner" is made by treating at length "the commoner affections, and those giving most distress and annoyance to the patient," while the "rarer diseases and those causing but little trouble have been dealt with briefly." While we cannot commend this method of gauging the relative importance of different skin diseases—necessarily assigning an undue prominence to certain simple affections—yet it, no doubt, contributes to the object the author has in view.

We have before given our opinion of this class of books. This multiplication, however, is proof of their appreciation and indorsement by the profession. Dr. Van Harlingen's book compares favorably with similar works recently noticed in this JOURNAL, and is in some respects better. Its chief excellence is found in the therapeutical portion, which is brought up to the latest advances made in the practical department of dermatology. He gives a large number of formulæ embracing many new drugs, and combinations which recent experience has demonstrated to be of superior efficacy. His selections have been made with judicious care, and from many reputable sources. In this respect the book is superior to many larger and more pretentious works.

Received.

Dermatitis Herpetiformis, by L. A. DUHRING (Reprint).

Case of Dermatitis Herpetiformis aggravated by Pregnancy and irregular Menstruation, by L. A. DUHRING (Reprint).

Notes of a Case of Dermatitis Herpetiformis extending over eleven years, by L. A. DUHRING (Reprint).

Wo stehen wir heute gegenüber der Syphilis? Von H. AUSPITZ (Reprint).

Ueber Syphilis-Statistik, von H. AUSPITZ (Reprint).

On Urticaria Pigmentosa, by T. C. FOX (Reprint).

On Impetigo vel Porrigo Contagiosa, by T. C. FOX (Reprint).

Pathology of Paget's Disease of the Nipple, by L. A. DUHRING (Reprint).

A Manual of Dermatology, by A. R. ROBINSON, M.B., etc. New York, Bermingham & Co., 1884.

La Dermite esfoliativa Universale quale trasformazione del Psoriasi, by Prof. DR. PIETRO GAMBERINI (Reprint).

Du Lupus et de ses rapports avec la Scrofule et la Tuberculose, par EMILE RENOARD. Paris, 1884.

A case of Universal Psoriasis, by A. H. OHMANN-DUMESNIL (Reprint).

A case of Symmetrical Vitiligo, by A. H. OHMANN-DUMESNIL (Reprint).

Album Clinico de Dermatologia publicadas por la Revista de Medicina y Cirugia Practicas. Lamina 1-26, Madrid, 1884.

Item.

DELUSIVE HOPES AND SKIN DISEASES.—DR. SHOEMAKER.—MAVERICKS AND A PLEA FOR DERMATOLOGY.—Dr. Brocq, correspondent for Piffard's *Journal of Cutaneous Diseases*, writing from Paris (August number), says the physicians, doctors somebody—don't remember names—are using chrysophanic acid *internally* and by hypodermic injection, *in all sorts of skin diseases*, with wonderful success. He gives a most marvellous showing of cases and results, some sixty odd cases, not only parasitic diseases, but *all sorts, cured* by this method.

Well, being especially interested in the subject, we felt good; we felt as if we had dropped on to something extra, something not generally known, and that hereafter curing little old cases of eczema and "tetter" was going to be mere child's play. As for the parasitic skin diseases, old *Trichophytosis* and *Favus* and *Chromophytosis et id om. gen.*—we felt already quite equal to them, but here was, according to Dr. Brocq, a simple remedy, a *specific* for *all sorts of skin diseases*, no matter of what character; and we really felt as if we would like Piffard's journal of that particular issue, all to get burnt up, for fear this valuable piece of information would become generally known, and that then *anybody* could cure skin disease as well, better than we could, and thus would the old fellow's occupation be gone.

But in our old age we are getting suspicious. We rather feared it was too good to be true; so, before rejoicing, we thought we would wait, and get entirely out of the woods. Accordingly, we wrote to Dr. Shoemaker, the Philadelphia dermatologist, and asked him if it was "so"; if *he* had found chrysophanic acid, internally, a specific for skin diseases of all sorts. Now, of course, we didn't believe it was worth a cent, in any other class of diseases than the parasitic; we know it is useful in ringworm and other parasitic diseases externally, but its use for any other kind must be entirely empirical.

The doctor promptly and courteously replied that he had read the same article, and had given the chrysophanic acid a thorough trial. He gave it in $\frac{1}{4}$, $\frac{1}{2}$, and 1 gr. doses *per os* (had never used it hypodermically). He found it to be

an active cathartic; indeed, in proportional doses, a violent purgative; and that it had no other effect on the system. The skin disease got better immediately, as it will generally do under the administration of any irritant to the intestinal mucous membrane, but would resume its *status quo* on withdrawal of the medicine.

So, thus vanishes and fades away another bright hope which had cheered us a brief while.

By-the-by, the classification of skin diseases is very unsatisfactory; the treatment still more so. We should rather say the *various* classifications, for they are numerous, so numerous as to be misleading. The average doctor has a classification of his own, in which "eczema" largely predominates. In fact, everything that isn't something else is eczema; and with the general run of doctors there are only about two or three something elses. "Tetter" (whatever that is) is another large class, under which head goes a great many unrecognized diseases. A patient comes in: "ringworm" and "shingles" are excluded, differentiated, and the case is immediately classed as "tetter," or "eczema." We remember an obstinate case of herpetic eruption of a syphilitic nature, which promptly yielded to appropriate treatment at our hands, which had been treated *five years* for eczema; and also several cases of "tetter" (the laity call everything scaly or itchy: "tetter"), which we were enabled to dispose of simply by making a correct diagnosis.

Out here in Texas, all the unbranded calves are called "mavericks." Eczema is the maverick of skin diseases. If it isn't something else, some other brand, it is eczema. Eczema is the proteus also of skin diseases. A doctor knows that, in pronouncing a skin eruption "eczema," he has about forty chances in his favor of being right; if he calls it "tetter," he has about the same ratio. He accordingly prescribes Fowler's solution or iodide of potassium, sulphur or zinc ointment, may be uses some of the mercurials locally; and if in about six weeks the disease does not disappear, the doctor recommends the patient to go to Hot Springs.

Now this is all wrong. There are excellent works extant on skin diseases, illustrated with most faithful photographs, which, if properly studied, would enable any intelligent physician to have much better success in treating this obstinate class of diseases than now attends their efforts. The fact is, it is a difficult subject and a difficult study; and too often the *pay* is not commensurate with the labor and study; hence the subject, this important subject—one which seriously affects the health, happiness, comfort, and well-being of a large class in every community, is neglected; or, if attended to, it is slouched over—not thoroughly done, by a great many intelligent general practitioners.—EDITORIAL *Texas Courier-Record of Medicine*, Nov., 1884.

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NOTES ON THE TREATMENT OF AN EPIDEMIC OF RINGWORM OF THE SCALP IN A PUBLIC INSTITUTION.

BY

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“**T**ROUBLESOME and disappointing as the management of ringworm in ordinary practice is, it is infinitely more so in schools and public institutions.” This statement, which forms the opening sentence in an article by the late Tilbury Fox, on “Ringworm in Schools” (London *Lancet*, January, 1872), has since been corroborated by a number of writers, and doubtless correctly represents, if I may judge from verbal communications with many dermatologists, the experience of all who have had much to do with the treatment of the disease in question. It at any rate emboldens me to contribute my small quatum of experience with the subject, in the hope that a plan of treatment which I have recently been pursuing may prove equally satisfactory in other hands.

The true reason for the trouble and disappointment which attend the management of ringworm (of the scalp) in ordinary practice is doubtless the uncertainty attending the prognosis of the disease. This is well expressed by Alder Smith (“Notes on Croton-oil Treatment of Ringworm,” *British Medical Journal*, June 12, 1880, p. 885), who says that “it is most difficult to certify that any case of this disease is absolutely well. Time after time stumps that were not visible at one examination will crop up again, breaking off when any attempt is made to extract them, and reappearing again and again for months after the case in other respects seems cured.” Since even in isolated cases the disease often runs

on for six months or a year or more, despite reasonably thorough treatment, owing to the difficulty of determining with positiveness the period at which the case may be pronounced cured and a suspension of treatment advised, the difficulty is greatly increased when the patient is constantly surrounded by other cases of the disease, and lives in rooms the atmosphere of which is loaded with the germs of the fungus, as Tilbury Fox believed he had demonstrated.

The local measures on which reliance is usually placed to cure the affection as it occurs on the scalp, where it is notoriously much harder to deal with than when it is seated on the non-hairy portions of the body, are thorough cleansing of the parts, removal of all the hairs from the affected spots, and the application of agents possessing parasiticide qualities. Prominent among these are various preparations of mercury, sulphur, tincture of iodine, sulphurous and acetic acids, and vesicating agents. These are all used in the form of ointments or lotions, the application of which requires time and patience, and must be repeated once or oftener daily. That these and similar agents, which in the majority of instances succeed in curing the disease, do not always do so, is doubtless due to the difficulty of bringing them into direct contact with the parasite which is often found at the very bottom of the hair follicles.

Of late years a number of authors, attempting to utilize the fact of common observation that the vegetable parasite which causes the disease cannot live in the presence of pus, have advocated and practised in chronic, obstinate cases, the artificial production of the variety of the disease known as kerion. The agent which has been most used for the purpose is croton oil, painted upon the diseased patch until pustulation and deep-seated suppuration were produced. Alder Smith, who strongly advocated this plan of treatment, says that "care should be taken not to produce an actual slough of the upper part of the corium," and that sometimes, when even this powerful agent fails to cure the disease, he uses tartar emetic ointment as well, or equal parts of the bichloride of antimony and lard, which is most intensely escharotic, and always produces a bald place by destroying the follicles." But even this sometimes fails, and he believes that "there are undoubtedly inveterate cases that cannot be cured, but such always get well spontaneously about 15 or 16."

That this plan of treatment is heroic and severe in the extreme is, I think, evident to every one who has seen many cases of kerion, or the acute inflammatory form of ringworm of the scalp. An insignificant painless scaly patch is by this treatment suddenly converted into an œdematous, boggy, elevated mass covered with suppurating points and discharging a glutinous fluid, tender and painful, and generally the seat of intense burning and itching. If this condition last long, as it often

does, the hair-follicles may be destroyed, and permanent baldness and even cicatrization result.

I by no means deny that this plan of treatment may be effectual. But that it is needlessly severe, and even barbarous, I am strongly inclined to believe; especially in view of my experience with the disease during the past year, and its treatment by a measure the description of which is the sole object of this paper.

About one year ago I was requested to undertake the management of a number of cases of ringworm of the scalp in a large orphan asylum in this city. On my first visit about twenty children were brought forward, all under the age of twelve. On the head of each were one or more spots presenting the macroscopical appearances of typical trichophytosis. Specimens of hairs and scales were removed from each, and subsequent microscopic examination revealed the presence of abundant spores and mycelia of the trichophyton tonsurans, the former largely predominating. Inquiry showed that the method of treatment which had for a long time been followed in the institution, under the direction of two very skilful physicians, was isolation of the patients, cutting the hair, washing the heads, epilation of the patches, and the frequent and thorough application of a lotion of corrosive sublimate in some cases, and in others sulphur ointment. Careful inquiry and observation showed me that all these measures were properly applied, the lotion being briskly rubbed into the scalp with a small mop, in some cases several times daily. The hygienic surroundings of the institution were of the best, the food, sleeping apartments, and conveniences for cleanliness being all that could be desired. But in spite of everything, relapse after relapse occurred, and the attendants had begun almost to despair of ever being able to arrest the spread of the disease, which was rapid.

Investigation soon showed me that in the already crowded state of the hospital wards, complete isolation of the diseased children could not be carried out. Many of the least advanced cases were living in the main building, in which new cases were discovered nearly every day, in spite of the fact that all the patients wore caps.

Complete isolation of the patients being out of the question, the possibility of isolation of the disease was next considered, and it was believed, from past experience with the agent, that the use of *Liquor Gutta-perchæ* of the *Pharmacopœia* would accomplish the desired end. This substance, to the use of which in cutaneous therapeutics attention was first publicly called, I believe, by Ausspitz,¹ has the property of forming a thin artificial cuticle, which, unlike collodion, exerts no tension, does not become brittle, cannot be easily rubbed off, remains intact for sev-

¹ Med. Klinisch. Wochenschr., Aug. 4, 1883.

eral days, and is, I believe, impermeable. This last quality would, it was thought, give it an additional value when applied to a patch of ringworm, as by its use the supply of oxygen necessary for the life of the fungus would be cut off. It was thought desirable at the same time to apply with the gutta percha a reliable parasiticide, and the one chosen was the well-known chrysarobin. This agent was long ago used in parasitic affections of the skin by Fayrer, Simon, Smith, Liveing, and others, in the form of an ointment, but its use in this manner was attended with so many drawbacks that it was by many abandoned. As I had found that these objections to its use, such as the staining of hair and clothing and the production of dermatitis, could be almost entirely obviated by applying it in the form of a pigment with the gutta-percha solution, I saw in them no contra-indications to its use in the present instance. An additional reason for using it was that it possesses in an eminent degree the faculty of producing what is usually aimed at in the croton-oil treatment of ringworm, viz.: the power "to produce an inflammation involving tissues at least to the depth of the hair-follicles."

In using the pigment of chrysarobin (of the strength of ten per cent in *Liquor Gutta-perchæ*) it was hoped that three objects would be accomplished, viz.: the isolation of the patches of diseased skin, the exclusion of oxygen from the fungus, and the direct destruction of the latter by the action of the parasiticide. The method of using it was as follows: The hair was closely cut or shaved on all the heads which presented scaly patches; the scalp was thoroughly cleaved, and epilation by forceps of the hairs on the spots and for a short distance around them was practised. This left a clear, bald spot, the centre and greater part of which was thickened, infiltrated and of a dark-gray color, contrasting sharply with the healthy skin around it. This discolored area was then covered with a layer of the pigment applied with a stiff brush. Nothing further was done until the artificial cuticle began to crack, or until the growing hairs pushed their way up through it. The application was then renewed, and this was done twice or thrice a week. No attempt to isolate the patients was made, and no other precautions taken except to make them wear caps, to insist on frequent inspections and thorough cleanliness, and to attend to their general health. Cod-liver oil or iron were administered to such as seemed to require them.

The effect of this plan of treatment, which was at first used cautiously and with some misgivings, soon became apparent. The great diminution in the amount of attention required by each patient was exceedingly gratifying to the overworked attendants, and they were enabled to devote much greater care to seeking for new cases. The number of these among children who had been for some time in the institution soon

¹ W. Cottle, *London Lancet*, May 1, 1880, p. 697.

began to diminish, and in a short time only the recent arrivals would be found to present evidences of fresh attacks of the disease. Every head was carefully examined at frequent intervals, and each scaly patch was at once covered with the yellow pigment, in many cases without previous epilation. After this plan had been followed for two or three weeks, the matron of the institution, whom I found to be a most careful clinical observer, remarked to me one day: "Doctor, that yellow paint seems to kill the ringworm at once." So much pleased was she with it in fact, that at my occasional visits I found that there was but little need for my services, all the cases of even suspected ringworm being submitted in a routine way to the treatment, without awaiting a positive diagnosis, and all, with but few exceptions, doing well. The exceptions were rare instances in which a pustular dermatitis was set up by the pigment, and in these, of course, its use was suspended. In many of the fresh cases one or two applications of the mixture, without epilation, at once put an end to the disease.

Occasional relapses did occur, of course, but they were always due to the premature (as it proved) suspension of the treatment and the substitution of inunctions with carbolated vaseline. A return to the pigment and the continuation of its use for a number of weeks longer, generally sufficed to complete the cure. A number of cases of the pustular dermatitis mentioned above (which sometimes spread over the entire scalp) were the only unpleasant effects of the treatment, but in not a single case was a true kerion produced. That the epidemic has been entirely stamped out at the date of this writing I cannot claim, but at a recent visit to the institution, although I saw a large number of children with the familiar yellow spots on their heads, I was unable to recognize a single well-marked case of ringworm. The application of the pigment to every scaly patch has become a routine practice in the asylum, and doubtless a number of cases of squamous eczema have been regarded and treated as ringworm. Another curious fact about the epidemic has been that only two or three cases of ringworm of the non-hairy skin have been found during the year.

Although my experience with the plan of treatment detailed has not been sufficiently large to enable me to assert that it will cure all cases (probably not more than sixty patients having been treated during the epidemic), yet I feel warranted in recommending it for trial, in the confident belief that it is capable of radically curing a large proportion of cases of this disease (and doubtless also of favus), with a minimum of trouble to the attendants, and of suffering and annoyance to the unfortunate victims of this exceedingly troublesome malady.

CANITIES.

BY

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SYNONYMS:—Trichonosis eana; Trichonosis discolor; Poliothrix; Poliosis; Trichonosis poliosis; Trichosis poliosis; Spilosis poliosis; Polioties; Grayness of the hair; Whiteness of the hair; Blanching of the hair; Atrophy of the hair pigment.

Grayness or whiteness of the hair may be congenital or acquired; and of these, the latter is by far the most common. The whiteness is either partial or complete.

Congenital canities usually occurs in the form of tufts, sometimes in round patches, the more or less pure white hair showing conspicuously amongst the normal-colored mass. When the whiteness is general, we have albinism which is associated with a deficiency of pigment in the whole body. Cases of congenital canities are rare.

Acquired canities may be premature or senile. Most often grayness does not begin before the thirty-fifth to fortieth year. If it occurs before this age, it may be considered as premature; and when after this age, as senile. Premature canities is by no means uncommon, many persons becoming gray between the twentieth and twenty-fifth year. The hair which, as a rule, first whitens is that of the temples; then follows, with more or less rapidity, that of the vertex and whole head. Sometimes the beard first turns gray, but usually it changes color after the hair of the scalp. The last hair to become gray is that of the axillæ and pubis. When the graying is due to some passing cause, as anxiety or some diseased state, the process may cease completely upon removal of the cause. Instances have been noted of normally-colored hair growing in after the fall of the white hair, but usually the whiteness is permanent. When graying of the hair is due to senile changes, it is progressive and permanent. As a rule, there is no change in the color of the scalp, though in some cases gray tufts are found upon pale-yellow patches of scalp. As in alopecia, so in canities, men are more frequently affected than women.

The hair in canities is usually unchanged except in color, but it may be drier and stiffer than normal. Canities may exist for years without alopecia. In the senile form, alopecia is apt to come on as another senile change; alopecia senilis, as is well known, is generally preceded by canities. According to Landois, incipient baldness usually follows senile canities in from one to five years.

The hair turns gray first at its root, and not at its point, as has been maintained. The color at first is gray on account of the mixture of the

normal color and the whiteness due to the absence of pigment. Gradually, the white parts gain the ascendant, and the whole hair is blanched, becoming finally of a yellowish or snowy whiteness. The darker the hair is originally the more it is prone to turn gray.

Sudden change of color of the hair from its normal hue to perfect white has been too well authenticated to allow of a doubt as to its occurrence, though it has been denied by good authorities, who have questioned the correctness of the observations reported.

Leonard¹ gives a long list of cases, including those of Marie Antoinette, Mary, queen of Scots, and others. Landois² reports fully a case of this sort observed by himself. It occurred in the person of a man, thirty-four years of age, who was admitted to the hospital suffering with delirium tremens. His delirium took the form of great terror whenever any one approached him. On admission, his hair was of blonde hue, and was so up to the evening of the third day. On the morning of the fourth day, the hair both of the beard and scalp was noticed to have become gray. Some of the hairs were white from root to point, some only at their roots, some only at their points, while some were white and blonde at different points. A careful perusal of the reported cases will be sufficient to convince one of the reality of sudden blanching of the hair.

Ringed hair is an anomalous variety of blanching of the hair in which the affected hairs are marked by alternate rings, one being that of the normal color, and the next white. The occurrence of this disease is very rare, and but few cases have been reported.³ In Wilson's case, the disease had been progressive for six years and affected only the scalp hair. The white portions occupied the entire diameter and were opaque by transmitted light.

The hair has been known to lose its color under varying circumstances. Thus Wallenberg⁴ reports a case in which, after an attack of scarlatina, the patient's brown hair was entirely lost and replaced by a growth of white hair. Prolonged residence in a cold climate, with much exposure, will cause the hair to turn gray. Sometimes the hair will change its color with the season, becoming gray in winter and darker in summer.⁵ On the other hand, Cottle⁶ gives prolonged residence in hot climates, with much exposure, as a cause of canities. Albinos, we know, are most frequent in the negro races, which inhabit the hot countries.

¹ "The Hair, its Diseases, and Treatment." Detroit, 1881.

² Virchow's Archives, 1866, xxxv., 575.

³ Wilson, E., Tr. Roy. Soc., 1867; also see "Healthy Skin," London, 1876, p. 109.

⁴ Arch. f. Derm. und Syph., 1876, Heft 1.

⁵ Wilson, Lect. on Dermat., 1878, p. 171.

⁶ "The Hair in Health and Disease," London 1877.

Etiology and Pathology.—Senile canities and many cases of the premature form are due to an obscure change in the nutrition of the hair papillæ which interferes with the production of pigment. Whatever the nature of the change may be, only this function of the papillæ seems to be interfered with, as the hair-forming function is in full activity, judging from the fact that the hair in many cases is in full vigor. The hair depends, for its shade of color, upon the color of the hair cells, upon the color of the hair pigment, and upon the amount of air contained between the hair cells. It is from the outer layers of the hair that it chiefly takes its color tone. Thus often under the microscope a large amount of pigment cells will be found in the medulla of a hair that appears white. In cases of sudden blanching of the hair, the change of color is dependent upon the formation of air bubbles between the hair cells of the cortical substance, the presence of the air rendering the cortical substance opaque, so that the color of the pigment is obscured. If one of these hairs is placed in hot water, ether, or turpentine, the air bubbles will be driven out, and the hair will reassume its normal color. This same infiltration of the hair with air will be found also in some cases of ordinary premature canities, though most of such cases are due, as above stated, to interference with the production of pigment. According to Pincus,¹ in the beginning of canities the pigment slowly leaves the middle layers of the papillæ and remains alone in the external layers. With the increase of the canities, only a portion of the external layer of the papillæ will produce pigment, which in straight hairs will run in streaks parallel to the long axis of the hair, and in curly hairs will run in a spiral. The blending of the colored and uncolored streaks will produce the gray color, which will gradually change to white as the pigment is less and less produced. There are various agents which act as active or exciting causes of canities. Age is one of the most prominent of these. Heredity exerts marked influence upon the blanching of the hair, most of the members of certain families turning gray at an early period of life. Neuralgia of the fifth nerve, dyspepsia of various forms, sudden fear or nervous shock (producing sudden blanching of the hair), abundant and frequent hemorrhage, excesses of all kinds, chronic debilitating diseases (as syphilis, malaria, and phthisis), local diseases or injuries to the scalp, as wounds, favus, repeated epilation, prolonged shaving, and the like, have been given by various writers as causes of canities. Schwimmer regards it as being principally a tropho-neurosis, and finds in the occurrence of grayness in the course of neuralgia a strong argument for his theory.

The cause of "ringed hair" is ascribed by Wilson to the development of a gaseous fluid within the hair, and he thinks that either the white, opaque and smaller segments were developed during the night, and the

¹ Arch. für Derm. und Syph., 1872. ii., 1.

larger and normal segments grew during the day; or, the separate segments were the product of alternate days. The gas may have been generated at the time of the formation of the abnormal segment, or the cells which composed that segment may have been originally filled with an aqueous fluid which evaporated quickly, and was replaced by air penetrating from without. Landois¹ does not think that the white places are the products of the growth by night, and the dark by day; nor that the white places were due to drying of the hair elements. He believes that we must assume an intermittent activity of the trophic or vaso-motor nerves of the pupillæ through whose influence a hair tissue is formed, in which a periodic development of gas takes place. The solution of the question is still in abeyance.

Treatment.—We cannot restore the color to gray hairs. In some cases of canities occurring in the course of neuralgias, if we can cure the neuralgia, the color will gradually return to the hair.

All that can be done for canities is to artificially restore the color by means of hair dyes; and their use is to be deprecated. Happily the custom of dyeing the hair is falling out of fashion. We append a few formulæ for hair dyes, selected out of many.

Hair Dyes.—Hebra and Kaposi give directions for the process of dyeing the hair black by “Henna.” This is made into a paste with water and spread upon the hair. In an hour the hair will be red. Then a paste is applied to the hair made from powdered indigo plant. Then damp heat is applied, and in a few hours, if experience and good judgment have regulated the process, the hair will have a fine, black color.

Leonard gives the following preparations for dyeing the hair black:

No. 1.

℞ Bismuthi citratis.....	℥ i. = 32.
Aquæ rosæ.....	
Aquæ destillat.....	āā ℥ ij. = 64.
Alcoholis.....	℥ v. = 20.
Ammonia.....	q.s. = q.s.

Sig. Apply in the morning.

No. 2.

℞ Sodii hyposulphit.....	℥ xij. = 48. (60.)
Aquæ destil.....	℥ iv. = 128. (140.)

Sig. Apply in the evening thoroughly to the hair.

Nitrate of silver may be used in the strength of from five to ten grains to the ounce, saturating the hair with the solution, and allowing it to dry in the sun, or in the light in a warm room. If it is wished to hasten the process, an application of sulphuret of potash, of twenty grains to two drachms to the ounce of distilled water, will cause the dye to set instantly.

¹ Virchow's Archiv, 1869, xlv., 113.

Gloves should be worn when applying this dye, and a brush used to lay it on.

Lead may be used in the form of the sugar of lead, ten to twenty grains to the ounce of water, applied to the hair, and when about to dry following it up with a solution of sulphide of ammonium about one quarter the strength of that of the British Pharmacopœia.

Mercury may be used in the form of the bichloride three grains to the ounce of water brushed through the hair and followed when dry with a solution of hyposulphite of soda, one ounce to two ounces of water. The last two dyes are dangerous. For a brown dye Pfaff recommends a pomade composed as follows:

℞ Ol. ovorum rec. press.,	
Med. oss. bovis	āā 50.
Ferri lact.	2.50.
Ol. cassiæ ether.	1.50.

The number of dyes is legion, and the above must suffice as examples. Before the application of any dye, the hair should be thoroughly cleansed with soap and water.

CHRONIC PRURITUS.

BY

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IN January, 1884, Mrs. E. H. D., aged thirty-one, presented herself at my clinic for skin diseases at the Woman's College. She stated that the eruption on her body had existed since early childhood and had been treated by several physicians, with only partial relief. Inspection showed the greater part of the body, particularly the extensor surfaces of the legs and arms; the neck, face, back, and breast, was covered with numerous brownish pigment spots, ranging in size from a quarter to one-half inch in diameter. The spots were round, oval, or irregular in outline, and have remained in this pigmented condition for many years. Closer inspection revealed a slight depression in the centre of these stains. Many have undergone atrophic changes and now present pearly-white cicatrices. On the breast, where the irritation first appeared when she was a child, the pigment has become entirely absorbed and there exist a large number of small depressed cicatrices that resemble somewhat the pitting of small-pox. It seems rather remarkable that the part of the body usually in ladies covered by the corsets, has a very few, if any, lesions. She has informed me, however,

that this region has by no means been exempt from the irritation, but the thick covering has prevented the free use of the finger-nails whenever she might have a desire to scratch. The macules so far described are unquestionably secondary lesions, and have been produced by the finger-nails. She informed me that a certain part of the body would itch to such an extent that she could get no relief until the spot was scratched out, and as she now regards the pleasure of scratching no particular compensation for further delay she immediately commences the lacerating process. I have most carefully, and on different occasions, examined the skin for some manifestations worthy to be called primary lesions, but they evidently are not to be found. I am, therefore, led to believe that we have to deal with an aggravated and exceedingly chronic pruritus. I am not certain as to the true cause of this affection, although it would seem from the treatment that the nervous system was mainly at fault. She certainly has no organic disease that can be discovered, and the different functions of the body are carried on in a healthy manner. Careful and repeated examinations of the urine have been made, but no abnormal products have been found that, as far as we know, could in any way influence the disease. The lady has two children, the elder a boy in good health and without any history of cutaneous disease; the younger, a girl, two years of age, healthy, rosy, and plump, and without the slightest appearance of any cachectic condition. Three months ago this child commenced scratching the skin, and it was for her relief that the mother again consulted me. Examination revealed a few isolated pigmented spots on the legs and arms, and with the same peculiar depressed centre that has already been described in the mother. The mother informed me that she had closely watched the parts when the child was in the act of scratching, but could see nothing upon the skin. In my recent examination I have not been able to detect any primary lesions such as may be observed in prurigo or lichen planus. These cases are not only unique, but offer peculiarities for speculation. The fact that the pruritus has existed during the life of the mother, and, as she affirms, a similar eruption was present upon the body of her mother, a child of a later generation also similarly affected, shows a peculiar persistency and a seemingly hereditary transmission. For the benefit of any one who would endeavor to explain these local phenomena by the unsuspected existence of a few scattering pediculi, it must be said that, for the present at least, there is no evidence whatever of their presence. Another argument against this supposition is, that the little brother, who occupies the same bed, has no cutaneous disease visible. It is not necessary to take up valuable space in your journal in giving a complete synopsis of the treatment so far instituted. It is sufficient for the present purpose to state that we have endeavored

to allay the irritability of the skin by different combinations of anti-pruritics. The best remedy so far used has been a solution of naphthol. It certainly has proved a great boon to her irritable skin, and she now receives almost complete relief. During the months that I have had her under treatment she has also taken internally a combination of iron, arsenic, and nux vomica. This treatment, given at intervals, has given tone to the nervous system, and has proved a very important adjuvant to the local measures. The treatment up to this time has so far controlled the pruritus that an ultimate recovery may be reasonably expected.

CHICAGO.

FAVUS IN AN INFANT.

BY

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ROBERT BERRY, healthy, well-developed infant born March 19, 1883, weight at birth six pounds two and one-half ounces.

Mother primipara, twenty-three years of age, always healthy. No family history of skin disease. A few days after birth, a red spot was noticed on right side of infant's head, circular in form, about five lines in diameter. Did not increase in size or present any characteristic appearance for the first four weeks after birth, when a small yellow cup-like disk, having well defined border, appeared in centre. This gradually increased in size and was followed by others. No treatment was given until infant was seven months old; at this time the original spot had increased somewhat in size, and in addition had sent out a spur-like prolongation posteriorly, eight lines in length by two in width. This as well as the circular spot was covered with favi of varying size numbering in the aggregate fifteen.

At this time the patient was first seen by Dr. Piffard, who pronounced it a case of favus, and confirmed the diagnosis by making a microscopical examination of one of the cups, finding the *Achorion Schœnleini* in abundance. Treatment—Removal of crusts. Painting surface with tinct. iodine. This was continued at intervals of from two to three weeks according to appearance of favus cups; the surface affected gradually becoming smaller and intervals longer before the appearance of the favi.

Seven paintings in all were resorted to, when the cups entirely disappeared leaving a slightly reddened surface. At this time the little patient left the Asylum and passed from observation.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

150TH REGULAR MEETING, DECEMBER 23D, 1884.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. ROBINSON presented a case of

SYCOSIS.

William C. has had the present eruption for six years, on both sides of the face and the right temporal region. The patches on the cheeks are sharply limited, there are no vesicles, no exudation on the free surface, *i. e.*, no signs of catarrhal inflammation, but dark-red corium infiltrated—a parenchymatous inflammation with isolated peri-follicular pustules and indurated tubercles.

On the temple the eruption is chiefly confined to isolated hair-follicle areas.

On the chin a parenchymatous inflammation with less infiltration than on the sides of the face, and with many pustules perforated by hairs.

The eruption has always remained confined to the bearded portion of the face and the right temple, commencing in the latter situation.

The inflammation has periods of intensity followed by more subacute symptoms. The patient has never had eczema, but is subject to boils.

DR. ROBINSON then showed another case of

SYCOSIS.

The patient, a man, forty years old, has had the present eruption for the past sixteen years; the chin and cheeks as far as the sides of the nose, being involved. The case is almost similar in appearance to the one previously shown. There is a considerable amount of atrophy of the hair-follicles of both cheeks.

DR. TAYLOR said that it was within the bounds of reason that the lesion in both of these cases was one of sycosis. He knew that long-continued inflammation would be followed by atrophy; he presumed that the diagnosis was correct, although he must say that the appearances in the first case were strikingly suggestive of lupus.

DR. PIFFARD said that he was not prepared to express an opinion in regard to the first case. He thought that the second case was what was called a sycosis, an eczema with involvement of the hair-follicles.

DR. ALEXANDER, at first sight, thought that the lesion in the first patient was more like a lupus. Both cases, however, bore a great resemblance to chronic erythematous eczema. He was not accustomed to recognize sycosis, except in the parasitic form. He would say that both the lesions were erythematous eczemas, with accompanying pustular eczema around the hair-follicles.

DR. ROBINSON said that he showed both cases on account of the similarity in the appearance of the skin, *viz.*, a parenchymatous inflammation in contradistinction to a catarrhal inflammation, as seen in ordinary eczema. These cases correspond more nearly to a pustular eczema. As to the question of name, there is evidence of a parenchymatous inflammation in a chronic form, all the hair-follicles not being destroyed, and this is sufficient to keep up an inflammation. The disease originates as a peri-follicular inflammation, which finally passes into the chronic parenchymatous form. Where areas of purulent inflammation exist, there is a destruction of normal tissue, and a consequent formation of cicatricial tissue. He thought that so small a loss of tissue, as seen in the second case

which had lasted sixteen years, was of very rare occurrence in ordinary eczema. There is a condition called follicular eczema, and he now had a case under observation in which the eruption covered the legs, thighs, scrotum, and umbilicus; there was no elevation, nor pustules, only vesicles; on the thigh there were patches the size of the thumb; on the scrotum and umbilicus a chronic eczema existed, while on the legs there was a follicular inflammation.

DR. ALEXANDER asked if there were apt to be a destruction of tissue and a striated appearance of the chin as noticed in the second case.

DR. ROBINSON said that in cases which had lasted a long time there would be atrophy of the tissues, and that these striæ would correspond to the areas of distribution of the hairs.

DR. ROBINSON then exhibited a case of

TROPHIC LESIONS OF THE SKIN FOLLOWING CEREBRAL HEMORRHAGE.

Rosanna N., aged thirty-three years. Married. Has two children, the older seven years, the younger four, both living and healthy. She has had no miscarriages.

Never had any eruption on the body previous to an attack of paralysis. Had paralysis of the left arm and leg, the eyes were turned crossways, no paralysis of the muscles of the face. She was more or less insensible for two days.

The eruption appeared two days afterward, like a "cold" eruption, with spots on the left ala of the nose, front of the ear, temple, and on the scalp, all being situated to the left of the median line; no eruption on the right side of the face.

At the present time (July 14), the left ala of the nose is almost destroyed, at the apex it has not extended quite to the median line. The base of the wound is red, non-ulcerating, easily bleeding, the margin is not elevated or indurated, there is no surrounding inflamed areola and no tubercles or cicatrices.

On the side of the face directly in front of the ear are two pea-sized spots of similar character, but there is only slight loss of tissue.

On the scalp there are six isolated spots, pea to bean sized, with the same characters.

All these spots are on the left side and the eruption extends exactly to the median line.

A few cicatrices, the result of previous necrosed spots, are to be observed in the same regions. The age of an individual lesion varies. All appear suddenly and present the character of an acute serous inflammation with rapid destruction of tissue.

DR. ALEXANDER said that the lesion looked very much like those cases which had been described under the name of eczematiform syphilis, examples of which he had occasionally seen. He thought that the lesions were due to syphilis and that they occurred on one side because of the cerebral apoplexy.

DR. SHERWELL did not think that the affection was produced by syphilis.

DR. TAYLOR said that he did not believe that the lesion was caused by syphilis, because in this case there was first an inflammatory condition followed by a necrosis of the tissues, whereas in syphilis there was round-cell infiltration with subsequent breaking down of the tissues.

DR. ROBINSON said the individual lesions disappeared without treatment and showed some cicatrices behind the ear, the site of a former eruption. He believed it to be an acute inflammation of some kind.

DR. ALEXANDER then gave a brief resumé of a case of

CHRONIC ERYTHEMATOUS ECZEMA COMPLICATED BY CHRONIC NASAL CATARRH.

The patient, a young man, about eighteen years old, had a chronic erythematous and moist eczema situated mainly around the mouth, on the face, and neck as far as the clavicle. He also had cleft palate and chronic nasal catarrh. The eczema

* was worst on the upper lip, gradually shading off into the surrounding tissues. There was but slight benefit under ordinary treatment. He was taken to a throat specialist, as there was an impediment in his breathing, being unable to breathe through his nose. Two masses were found and removed from the region of the middle turbinated bones by means of a snare, the mucous membrane was not treated. Since then the eczema has disappeared, although slight nasal catarrh remains. He believed that this was a clear case of eczema from reflex causes and that the same diseased condition existed in the nose as on the face.

DR. PIFFARD asked the following question :

SHOULD A PERSON AFFECTED WITH PSORIASIS MARRY ?

He said that he had a patient suffering from a moderate psoriasis who asked him his opinion as to the propriety of marrying. Dr. Piffard said that he would like to have an expression of opinion, from the members of the Society, on the subject.

DR. TAYLOR said that he had seen many cases in which psoriatic patients had perfectly healthy children. In giving an opinion, he would be influenced by the length of time the eruption had existed, as well as its activity. If the question were propounded to him, he would say that if the patient suffered continuously from the disease, or if the attacks were severe, he would advise the patient not to get married, but if the attacks were ephemeral, he did not see any objection to marriage. In his mind there was no question as to the heredity of psoriasis, but it was generally in inveterate cases of long standing.

DR. SIERWELL could see no reason why a patient thus affected should not get married. He looked upon psoriatic patients as among the strongest persons. He had seen only one unhealthy patient, among several hundreds, and he had fibroid phthisis. In fact, he believed that the occurrence of psoriasis was an indication of health.

DR. ROBINSON would certainly advise psoriatic patients not to get married unless there was some other good reason aside from the question of health. He said that psoriatic persons were often unhealthy, and cited a case of a patient with psoriasis in whose immediate family two persons died of phthisis and another had scrofuloderma.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

RED CHROMIDROSIS, ITS PARASITE—LOCAL ASPHYXIA OF THE EXTREMITIES AND ATHEROMA—MYXEDEMA—ACNE OR FOLLICULITIS DECALVANS—TREATMENT OF ALOPECIA—ERADICATION OF SYPHILIS—CHANCRES OF THE TONSIL—EXTRA-GENITAL CHANCRES—INTERSTITIAL KERATITIS AND CHRONIC IRITIS OF LATE HEREDITARY SYPHILIS—CHRONIC MENINGITIS OF HEREDITARY SYPHILIS.

Red Chromidrosis, its Parasite.—Several months ago, there was a discussion on red chromidrosis by the Paris Academy of Medicine, in connection with a patient presented by Dr. Bergeron who was affected with this malady. Le Roy de Méricourt has recalled the struggle he was compelled to sustain from 1857 to 1864, in order to force the admission of the reality of this curious phenomenon. While isolated cases of chromidrosis had already been published, and the observations of James Younge (1709), of Lecat, of Billard, and of certain Irish physicians had furnished probatory evidence, yet it must be recognized that it was especially the researches of Le Roy de Méricourt which directed attention to

colored sweats, and after an active opposition forced the entrance of chromidrosis into the nosological category.

The patient of Dr. Bergeron was a young school-boy, twelve years of age, who presented in the submaxillary region and right side of the neck a transudation of red-colored material, the tint particularly vivid at the level of the prominence of the sterno-cleido-mastoid muscle. The affected points did not form distinctly limited patches, but were disposed in irregular trais; the white shirt was deeply colored in red. Le Roy de Méricourt, in examining the affected parts with a magnifying glass, distinctly saw reddish grains engaged between the lamina of the epidermis; under the microscope he perceived that the epidermic lamellæ were charged with fine rosy granulations; the next day he found towards the periphery quite a large number of irregular corpuscles colored in blue, quite similar to those described long ago in chromidrosis.

This question has been taken up by Drs. Balzer and Barthelemy, who have published an interesting article on colored sweats in the *Annales de Dermatol. et Syphilig.* (June, 1884). Their investigations have been confined to red chromidrosis of the axillæ. They report the case of a man, aged thirty-four years, who, after an attack of typhoid fever, noticed that his perspiration, which had always been very abundant and odorous, presented in the axillæ, but nowhere else, a marked reddish tint, leaving upon his shirt an extensive patch of the same color. With the appearance of the colored sweat, the hairs of the axillæ, normally brown, gradually took on a reddish tint. They became rough, breaking easily, lost their lustre and suppleness, and presented a moniliform aspect. They resembled in color the stains on the shirt, which continued notwithstanding the daily use of lotions of soda soap, followed by applications of eau de cologne. To modify this abnormal secretion, alkaline baths, sulphur baths, lavender water, solution of sublimate (1 to 1,000); borax (1 to 8); chloral (1 to 30); salicylic, thymic, and phenic acids (1 to 20) were tried in vain. Aromatic vinegar and chloroform gave a certain amelioration; ether was found the most efficacious; by its employment the chromidrosis was suppressed for a while, although it reappeared in a short time. In carefully examining the hairs of this patient, and those of several other persons subject to red or yellow sweat, the authors were able to verify the greater number of the conclusions already formulated in memoirs by Ebberts and especially by Babes (V. *Journal de l'Anatomie et de la Physiologie*, No. 1, 1884).

Under a feeble power, the hairs are seen covered with yellowish or reddish masses, sometimes separated from each other by intervals at the level of which the hair is bare, hence the moniliform aspect which it presents. The yellowish or reddish masses are, as Ebberts and Babes have demonstrated, crossed with striations which converge towards the hair, and under a high power it is easy to be seen that these striations are constituted by round or elliptic chains of micrococci presenting a yellowish, reddish, or brownish coloration; these micrococci are embedded in an amorphous or homogeneous substance, which is none other than their glair and which is likewise colored.

The microbes are not confined to the hairs; when scrapings of the epidermis are examined they are found in considerable quantity, likewise agglutinated by an amorphous substance, but not all colored. There may be found in the axillæ numerous other microbes, besides those of red chromidrosis. It is only necessary to examine several persons in order to be convinced of the frequency of parasitic masses appended to the hairs in the axillæ. Red sweat is

ordinarily met with in feeble individuals, the lymphatic, the arthritic, and among convalescents.

Babes, basing his opinion upon the existence of a parasite, admits the possibility of the transmission of red sweat by contagion. Drs. Balzer and Bartheleny think that there is a form of parasitism which occurs as a transitory or permanent condition in a large number of individuals subject to profuse perspiration, and in whom masses of microbes, generally non-chromatic, sometimes chromatic, may develop. It would be quite interesting to pursue further researches in this direction, to ascertain if the colored micrococci we have just mentioned really constitute a well-defined parasite; if there happens to the perspiration something analogous to what passes in the case of red snow, and finally to discover the secret of the appearances and disappearances, so bizarre of this phenomenon, at present inexplicable.

Local Asphyxia of the Extremities and Atheroma.—Dr. Bouveret has published in the *Lyon Medical*, June 8, 1884, an interesting case of local asphyxiae of the extremities (*Maladie de Raynaud*) occurring in a woman, aged sixty-eight years, who lived in a village of Dunhes where intermittent fevers are endemic. She had at different periods of her life several attacks of marsh fever. In 1883, during the month of January, she perceived that the middle finger of her right hand had become cold, violaceous, and almost insensible. The other fingers of her right hand and those of the left hand then became affected, and the disease soon invaded the dorsal surface and palms of the hands. Sometimes also small livid patches showed themselves on the lower portion of the forearm. At its début, the asphyxia only occurred when the patient experienced a very decided impression of cold, but little by little it began to develop more readily so that the woman had to give up washing the dishes and the linen. Finally the feet were attacked. The patient had always by her side warm water in which to dip her fingers and toes when she experienced the least pain. The intensity of the cyanotic coloration varied according to the degree of cold, from a black to a livid tint with yellowish spots. Upon the black parts the anaesthesia was complete, upon those which were only livid the sensibility was enfeebled. This then would have been a typical case of the local asphyxia of the extremities described by Raynaud, if the patient had not also presented another lesion—an arterial atheroma so pronounced that the superficial arteries were plainly perceived to be hard and sinuous. The pathogenesis of the asphyxic accidents would appear to be in this case quite complex. The arteries of the limbs being atheromatous, the circulation in the extremities being already inactive, the least spasm of the small vessels sufficed to determine the appearance of morbid phenomena. It should not be forgotten that the woman had already had several attacks of intermittent fever, and that Messrs. Verneuil and Petit, in a recent memoir in the *Revue de Chirurgie*, have described a local asphyxia and symmetrical gangrene of the extremities of palustrian origin.

Myxœdema.—I shall simply call your attention to a case of myxœdema described by M. Hartmann in *La France Médicale*, Nos. 71 and 72, 1884. It treats of a woman, aged thirty-six years, who had never left Paris and had never been exposed to the exciting causes of the cachexia; she had never lived in insalubrious lodgings, and she had always had a sufficient alimentation. The disease began several months after an attack of erysipelas of the face, and developed with considerable rapidity.

Alopecia.—I should have liked to send you a resumé of the interesting and

highly practical lectures which Lailler delivered during the past summer at the St. Louis Hospital, upon the treatment of the tinea; unfortunately they have not all yet been published. One of them, upon alopecia, reported by Chevallereau, has appeared in the *France Médicale*; it contains several new ideas. The eminent dermatologist thus speaks of the diagnosis of the tinea pelade, a very rare affection, but little known, to which he has given the name of *acne decalvans*, and which develops during its course a definite calvities. In this form of acne, he says, there are ordinarily pustules and scales at the base of the hairs, there is death and loss of the hair; then after the cure of the acne element, there persists a cicatricial depression—a sort of crackled aspect of the derma—the patches present, finally, a more seborrhœic appearance. I myself have just seen a patient who was attacked more than a year ago with an alopecia of this particular form, which several physicians had already diagnosticated as an alopecia. In fact, at first glance it looked like an alopecia in patches, especially marked towards the vertex, at the level of which the integument appeared white, smooth, ivory like, altogether like a true alopecia; no seborrhœa, no scales, no crusts upon any portion of the hairy scalp. In examining it with more care, I discovered in two or three points, where the hairs still remained, a light rosy erythematous tint, a little more marked around each hair. The hairs which were surrounded by the erythematous areola were not at all adherent, the least traction sufficed to detach them, and it is certain that they would have soon spontaneously fallen out; on the contrary, the adjoining hairs around which the derma had not the red coloration were still perfectly solid. The condition might have been regarded as an erythematous lupus of the hairy scalp, but the lesion had not the circumscription, the aspect, the distinct appearance of this disease; the alopeciac parts did not present the least trace of a cicatrix; there were neither scales nor crusts. It was evidently produced by a sort of slow inflammatory process acting especially upon the hair-follicles, and resulting finally in complete, total and definitive atrophy of the follicle, and an irremediable alopecia. It was then, if the term be preferred, an acne or better a folliculitis decalvans, for there was not an actual papular and pustular acne, distinctly and frankly inflammatory. On the other hand, we should not confound cases of this kind with ordinary alopecias, in which we may always hope, at least in the earlier months of the disease, to obtain a complete cure.

To hasten the cure, which often takes place spontaneously, especially in the achromatic variety, more rarely in the other variety, Dr. Lailler advises that daily frictions be made with a flannel dipped in one of the following mixtures: alcohol, 60%, 100 grammes; essence of turpentine, 20 grammes; ammonia, 5 grammes; or alcohol at 90%, 100 grammes; sulphate of quinine, 1 gramme; essence of bergamot, 10 grammes; essence of wintergreen, 2 grammes.

It is also necessary, from time to time, to shave the scalp, and give, if need be, internal treatment to the patient.

Eradication of Syphilis.—The celebrated syphilographer of Lyon, Dr. Diday, in May last, gave a lecture at the Charity Hospital in Paris, upon the eradication of syphilis. Like all the other productions of this author, this savant contribution to the study of the excision of syphilitic chancre sparkles with so much of *esprit* and *verve* that a mere analysis of it must appear dull and flat. By a most brilliant argumentation Dr. Diday has demonstrated that if excision of the indurated chancre fails in many cases to arrest the evolution of syphilis, in some cases, nevertheless, it has undoubtedly prevented the explosion of secondary

accidents. He counsels that excision should be practised in as large a number of cases as possible when the ganglia are not yet engorged.

Chancres of the Tonsil.—Paul Legendre has published, in the *Archives Générales de Médecine* (Jan. and Feb., 1884) an excellent article upon syphilitic chancres of the tonsil. He there shows that this localization of the initial lesion is far from being so rare as is generally supposed. Pollet is one of the first syphilographers who published examples of this nature, then Diday in his study of chancre of the tonsil (1861–1862) mentions 8 cases; M. Legendre, in his article reports 13 cases; 3 of Dr. Helat, 1 of Dr. Barthélemy, 1 of Dr. Morel Lavaller, 1 of Dr. G. Hue, 1 of Dr. Merkley, and 1 of Dr. Spillmann. Five had not been published, and of these five cases two came under the author's observation; one was a case of Dr. Lannois, and two were my own. The interesting feature of most of these cases is the errors of diagnosis which chancre of the tonsil occasions. The first case of Dr. Legendre was mistaken for diphtheritic angina, for which the patient was conscientiously treated during several days; there was a slight fever, an extreme fatigue, an indefinable malaise, a generally bad condition. The affected tonsil was enlarged, covered with a thick coating, grayish and quite adherent, the submaxillary and likewise the cervical ganglia were much engorged. In one of my cases, the patient had been supposed to be suffering from a gangrenous angina, the tonsil was much tumefied, and presented on its superior surface a blackish patch of sphacelic aspect, a centimetre in diameter, with clearly defined borders, and separated from the surrounding tissues by a sort of furrow of elimination filled with pus. The submaxillary adenitis was enormous and slightly painful. The true diagnosis was not made until a month later, after the appearance of secondary symptoms. In another case, still unpublished, which I have this moment found among my notes, the patient was treated for more than a month for a chronic angina. In the case of Merkley the patient, aged sixty-four years, presented behind the ascending ramus of the left inferior maxilla a large, hard, lobulated, painless tumefaction. An examination of the throat brought to view a deep ulceration, irregular in outline, with pultaceous floor, occupying the left tonsil and having apparently completely destroyed it. The surrounding tissues were indurated, and gave to the finger the sensation of a ligneous consistence. Dr. Verneuil did not hesitate to pronounce it an epithelioma of the tonsil. In Lannois' case, the chancre was mistaken for an ulcerated gumma; the tonsil presented on its entire surface an ulceration which penetrated to the centre of the organ. Reddish granulations occupied its base, and at certain points grayish lamina of necrosed tissue were detached.

It will be perceived that the errors in diagnosis are quite frequent in chancre of the tonsil, and that these errors are, to a certain extent, justified by the variability in the objective characters effected by the primary syphilitic ulcerations in this region. M. Legendre has not thought it necessary to describe the erosive, ulcerous, diphtheroid, gangrenous varieties of chancre of the tonsil, but he has justly observed that these are deceptive aspects which the accident may assume and which should not mislead the physician. In all such cases induration of the neighboring parts should be carefully examined—induration is always present, submaxillary adenopathy is likewise constant, indolent, unilateral, and very often constituted by one enormous ganglion, which is very hard, almost immobile, and surrounded by several smaller ganglia. These characteristics will permit a diagnosis in a majority of cases. M. Legendre terminates this remarkable study of chancre of tonsil with the remark that the

cause of this special localization of the primitive accident of syphilis is not always due to depraved practices. Among the thirteen patients whose history he reports in his memoir, were seven men and only six women. One of these six women had been infected by sucking the nursing bottle of her syphilitic child; another in kissing a child which had mucous patches of the lips. He is thus rather disposed to admit that inoculation of the tonsil is most often affected by the intermediary of contaminated saliva, and not by direct contact.

Extra-genital Chancres.—Drs. Lavergne and Perrin have published in the *Annales de Dermatologie et de Syphiligraphie* (June and July, 1884) a report of the extra-genital chancres which they have observed in 1883 at the St. Louis Hospital, in the service of Prof. Fournier. In one year and in one service of this wonderful hospital, which has six services equally important, and the clinical richness of which can only be appreciated by a long attendance, these conscientious observers have collected twenty-seven cases of extra-genital chancres, which may be divided as follows: Lips, 10; eye and eyelids, 5; cheek, 2; anus, 2; nose, ear, neck, arm, finger, bosom, leg, thigh, each 1; total 27. As an interesting feature we note that among the twenty-seven patients, twenty-one were men, and only six women; that five times the contagion had followed the bite of a patient affected with buccal syphilides. In sixteen out of the twenty-seven cases, the mode of contagion was not discovered. This interesting work terminates with a monograph upon chancres of the eye.

Interstitial Keratitis and Chronic Iritis of Late Hereditary Syphilis.—Before the remarkable lectures of Prof. Fournier upon hereditary syphilis, of which I have given you a resumé, French physicians did not assign to syphilitic heredity the important influence in the multiple accidents of childhood and adolescence which had been until lately attributed to scrofula. Now, however, we are more familiar with these questions, and the numerous publications upon this subject show that they are the order of the day. Dr. Abadie has declared before the French Ophthalmological Society that he has adopted almost entirely the views of Hutchinson upon the syphilitic nature of parenchymatous keratitis. He includes in hereditary syphilis certain forms of iritis presenting *d'emblée* the chronic form, and accompanied with lesions of the fundus of the eye due to the same specific cause. This affection is met with, he says, among patients of from twelve to twenty years of age, and is curable by anti-syphilitic treatment. In these cases, it may happen that mercurial preparations and iodide of potassium fail; we should not be discouraged, but vary our treatment. Sometimes the syrup of Gibert is inefficacious, when mercurial frictions, subcutaneous injections of the bichloride, the combination of large doses of iodide with feeble doses of the sublimate will succeed. Sometimes even the abrupt suspension of treatment is followed by a marked amelioration of the symptoms, which only commences when all medication is discontinued, especially if this medication has been rigorously conducted for some time. This communication of Dr. Abadie did not fail to excite the protestation of Prof. Panas, who has always been opposed to the ideas of Hutchinson.

Dr. Parinaud, in response to the eminent Professor, declares that an examination of twenty-three cases of parenchymatous keratitis observed by him shows that this affection is especially apt to occur in children who were conceived when the syphilis of the parents was already old, and that it was consequently an expression of an attenuated syphilis of the parents. It is probably not a lesion directly syphilitic, but a lesion of degeneration due to the organic *déchéance* created by hereditary syphilis—that is, an indirect product of syphilis.

Chronic Meningitis of Hereditary Syphilis.—In a memoir in the *Revue Mensuelle des maladies de l'enfance* (Nov., 1883) Dr. Dreyfous has touched upon another obscure point of hereditary syphilis—the establishment of a direct line between certain cases of infantile chronic meningitis, heretofore attributed to tuberculosis and hereditary syphilis. It is undeniable that syphilitic meningitis exists; hereditary cerebral syphilis likewise exists; modern researchers, particularly those of Prof. Fournier, have abundantly proven this. It will be necessary, then, in the future to search with care for a history of hereditary syphilis in children who present symptoms of meningitis, and no matter how few vestiges of the disease exist, however doubtful the cases may be, institute anti-syphilitic treatment, this constitutes the patient's sole chance of safety, and should not be neglected.

Who knows, indeed, whether certain cases of tubercular meningitis with remissions and of prolonged evolution, which all the classic authors cite, were not pure and simple cases of hereditary cerebral and meningeal syphilis?

L. BROCCQ.

PARIS, November, 1884.

Selections.

THE SYPHILOCOCCUS.

THE notion that contagious diseases are propagated through the agency of microscopic organisms was entertained by many eminent authorities as far back as the beginning of the present century. With regard to syphilis, in particular, it was the belief of Cullerier that peculiar animalcules existed in the lesions of that complaint. In 1837, a parasite was detected by Donné, in the secretions of chancres and buboes, but he concluded that its presence was entirely accidental, and that it bore no specific relation to the malady. It appears, in fact, to have been nothing else than the *Vibrio lineola* already described by Müller. The earliest reliable data in this connection were those obtained by Hellier, who, in 1869, discovered in the blood of syphilitic subjects large numbers of micrococci bearing a marked resemblance, in their action upon the red corpuscles, to the micrococci of scarlatina. Klotzsch, in the same year, detected spores in syphilitic blood and in the cuticular débris of syphilitic psoriasis. Lorstorfer, in 1872, discovered in the blood of infected subjects what he believed to be the characteristic corpuscles of syphilis—round, shining objects, which gradually increased in size during several days, and finished by developing a “vacuole” of considerable dimensions. These results were variously estimated by the Vienna dermatologists; but the question as to the origin of syphilis remained still undecided. Professor Cornil, in his hospital lectures during the year 1878, makes a passing allusion to the parasitical theory, as plausible and even fascinating in itself, but as wholly unconfirmed by facts. In the same year Klebs made known the results of his researches, by which a new era was opened in the history of our subject, since, unlike the foregoing, they were based, for the most part, upon exact experiments and accurate observations. He presents the following as his general conclusions: “1. Syphilis may be transferred from man to animals by inoculation. 2. Human syphilitic products contain a low grade of specific organisms—micrococci and rods (Figs. 1, 2, 3)—which, cultivated independently, are characterized by the production of peculiar forms, the *helicomanades*

(Fig. 4). 3. By inoculating suitable animals with these latter, the human variety of syphilis is produced, as well as that which belongs to the inferior species." The successful experiments in this instance were performed upon two monkeys, one of which was inoculated (in 1875) with a culture-fluid; the other



FIG. 1.

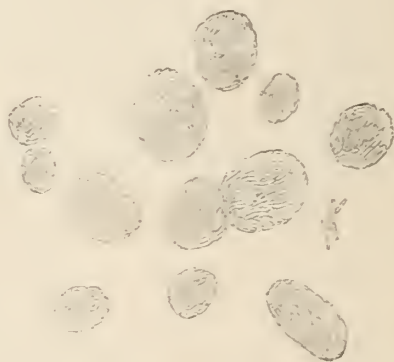


FIG. 2.



FIG. 3.



FIG. 4.

(in 1878) with excised portions of an indurated chancre. The former became affected with ulcers resembling syphilitic sores, in the buccal cavity and on the gums; the latter developed a papular eruption. No initial symptoms were observed in either, but the autopsies disclosed lesions which were taken for premature syphilomata.

In 1878, also, E. Cutter, of Boston, announced his discovery of mycelium in syphilitic chancres. He stated, moreover, that in syphilitic blood the white corpuscles were increased in size, and that it also contained bacteria and myceli-

um-filaments. Among the other American investigators in this department may be mentioned Bermann, of Baltimore, who attributes the syphilitic infection to spores and bacteria of a specific nature. The micrococci he found chiefly in the lymphatics; the bacteria in the arteries only. But these organisms resembled those described by Klebs.

Passing now to the German authorities, we find that, in 1881, Aufrecht, of Magdebourg, claimed to have detected in syphilitic papules a micrococcus of large size, occurring generally in couples, more rarely linked together by threes. It was strongly brought out by coloring with fuchsin. Ulcerated mucous patches, as also those which had been subjected to treatment, presented only a few of them. Obrazow, on the other hand, discovered colonies of micrococci in lymphatic glandular swellings attendant upon indurated chancres; also, in similar enlargements produced by chancroids, but here they were less numerous.

In 1882 the microbe of syphilis was the object of investigation in many different quarters. First in order came Birch-Hirschfeld, with the assertion that micro-organisms exist in all *gummy tumors* (excepting cicatrized gummata), and that they abound especially on the borders of the granulating tissue. He found them in *mucous patches*, in *indurated chancres*, and in a single case of *papulous roseola*. They were formed by the union of several cocci, usually in the shape of a long oval, which never included more than four or five individuals. Precisely similar elements were shortly afterwards described by Peschel.

On September 5, 1882, Martineau made a report to the Académie de Médecine concerning the *syphilitic bacteria* discovered by himself in conjunction with Hamonic. He had inoculated a pig by means of a culture-fluid in which an indurated chancre had been steeped for twenty-four hours. The culture-fluid contained two different kinds of bacteria and a few micrococci. Next day bacteria were found in the animal's blood. One month later, a "papulo-squamous syphilide" was developed. In the blood of another pig (four weeks old) bacteria were discovered four days after inoculation as above, followed likewise on the fourteenth day by a squamous syphilide. The bacteria in both these cases, when cultivated and inoculated into other animals, gave only negative results. These experiments were severely criticised by Koch, and in fact their significance is highly questionable, and the technical processes employed by no means beyond suspicion. The following, however, is of a more convincing nature:

On November 17 of the same year, a monkey was inoculated by Martineau with the secretion from an indurated chancre. Twenty-eight days later, two chancres, having all the typical characteristics of an indurated sore, made their appearance upon the animal's prepuce. These were succeeded by unequivocal secondary symptoms. In September, 1883, an ulcerated syphilide, which persisted for three weeks, had formed upon the velum palati. October 21, epileptiform paroxysms occurred, lasting four or five minutes each. December 3, an hypertrophic papulous syphilide was noticed on the right side of the scrotum, June 18, in the following year, another papulous syphilide appeared on the palate, remaining for fourteen days. After this, the monkey began to recover, and ultimately was restored to perfect health.

With the exception of the foregoing, all experiments on animals of different species—rabbits, dogs, pigs, goats, monkeys, etc.—by whomsoever undertaken, and though conducted with the utmost accuracy and skill, have proved entirely barren of decisive results, so far as the reproduction of syphilis is concerned. The writer's own microscopical examinations of chancrous secretions and frag-

ments which had been used for inoculations, revealed the presence of the microbe described by Klebs.

Morison has succeeded in proving the presence of bacteria in the diseased secretions of no fewer than fifteen variously affected syphilitic patients; in fact, he has never failed in a single instance. The matter from soft chancres he found to contain a distinct variety of bacteria, larger, more slender, and, except in size, resembling the bacteria of charbon. As a general rule, the blood of persons in health, or laboring under eczema pemphiginosa, yielded no such products, although, more recently, Morison has detected the same organisms in the ulcer of eczema impetiginosa, of acne, etc.

Neisser has published his belief in the parasitical origin of syphilis, and has advanced an ingenious theory in explanation of the course of the disease as related to the gradual development of its germs.

Barduzzi has lately observed, in the serum of a syphilitic pemphigus-bulla, numerous micrococci, as also bacteria formed by a series of small cells, each of which resembled a minute micrococcus surrounded by a gelatinous areola (Fig. 5). As shown by the accompanying illustration, objects grouped in this fashion scarcely deserve the name of bacteria.



FIG. 5.

De Tornery and Marcus have been experimenting in Vulpien's laboratory on the persistence of the microbe of syphilis. They give the following summary of the results so far arrived at: In syphilitic products and artificial cultivations, societies of cocci are observed, easily colored by Gram's method. The rods originally observed by Birch-Hirschfeld and Martineau are present in very small numbers; they disappear after the third cultivation, and are killed by a mixture of acid and alcohol at 3 per 100. M. and D. believe that these rods are due to septicæmia, or result from the juxtaposition of two or three cocci. The cocci are easily cultivated in beef-broth, to which is added gelatin and an alkali.

These investigations are decidedly interesting, and were more scientifically conducted than most of those which we have previously noticed. The micrococcus in this case would seem to be really the contagious agent in syphilis. We do not know whether De Tornery and Marcus have tested the virtues of their culture-fluid by inoculations, either of men or animals.

It should be mentioned before closing that Diday is an advocate of the parasitical theory of syphilis, and that Leloir has been experimenting in this direction for some years past.

It seems reasonable to infer from the statements which we have reviewed, 1st, that syphilis is a parasitical malady. 2d, that its microbe is probably a micrococcus, whose nature has still to be ascertained. 3d, That inoculations with the direct products of syphilis have been negative, or at least doubtful in their results, excepting in the case of Martineau's monkey, which is still a solitary instance. 4th, That inoculations with culture-fluids have been entirely unsuccessful, owing, perhaps, in part at least, to the defective methods generally pursued.—P. BRICON, *Le Progrès Médical*, Oct. 11, 1884.

NATURE OF LUPUS VULGARIS.

Two widely-differing opinions prevail at present among dermatologists respecting the essential character of the affection known as lupus vulgaris, tubercular

lupus, or the lupus of Willan. By some it is regarded as a species of cutaneous tuberculosis, confined (at least at its outset) to particular localities, and of primary origin; while others contradict this view, maintaining either that lupus consists in a peculiar neoplasm, entirely unrelated to tubercle, or that it is a distinct inflammatory affection of the skin.

In weighing the arguments adduced on either side, we must compare the leading features of the maladies in question—lupus and tuberculosis—as traceable in their clinical histories, their pathological anatomy, the results of experimental inoculations, and finally in the descriptions of their specific micro-organisms.

Clinical comparison. The symptoms of lupus vulgaris certainly differ from those of cutaneous tuberculosis properly so-called, as the latter have been delineated by Bazin, Vidal, and other authorities. But it should be remembered that two affections of the same essential nature do not uniformly exhibit the same symptoms. Moreover, if lupus be regarded as a *primary* tuberculosis of the skin, its external manifestations must necessarily differ from those of a tuberculosis *secondarily* affecting the same organ in an individual already under the full constitutional influence of the disease.

The relations between lupus and the strumous diathesis have long been a subject of debate, but it is only recently that clinical and statistical inquiries have been earnestly turned in this direction. The investigations of Fournier, Quinquaud, Lailler, and especially of Besnier, appear to prove that lupous subjects are more liable than others to contract phthisis, but that the complaint in their case frequently evades detection, because remaining for a considerable period localized, latent, and without effect on the general constitution, and because it is often manifested only in slight and transient attacks occurring at long intervals. In this paroxysmal form, phthisis is not of rare occurrence among lupus-patients. They are also rapidly carried off, in many instances, by an acute general miliary tuberculosis. At the St. Louis Hospital this termination has been found to occur in about one case out of seven. Minute and careful researches are still requisite for the settlement of this question. Its statistical solution is particularly difficult because, if lupus is a local tuberculosis, a longer or shorter period, sometimes a very long one, must necessarily elapse between the appearance of this local tuberculosis and the secondary constitutional infection. Lupus-patients, therefore, should not merely be thoroughly examined at the outbreak of their disease—they must be followed up perseveringly to the end, and this is not always an easy thing to do.

It has been asserted that lupus never affects the osseous system, but this rule is certainly not without its exceptions. I have the notes of a case occurring in the service of Dr. Lailler, where lupus of the face and throat undoubtedly extended its ravages to the bones of the nose, upper jaw and palate. It is, I believe, the first authentic instance of the kind on record. The patient died of acute general miliary tuberculosis.

The *pathological anatomy* of lupus, as unfolded by Friedländer and Koster, has demonstrated the absolute morphological identity of this disease with tuberculosis—an identity which is still more clearly shown by the fact that sclerous lupus, which bears to lupus the same relation that fibrous tuberculosis of the lung does to ordinary tuberculosis of that organ, exhibits precisely the same structure as fibrous tubercle.

Subcutaneous *inoculations* of animals with lupus-matter have for the most part been unsuccessful in the production of tuberculosis. By injecting the virus,

however (under strict precautions), beneath the peritoneum or within the anterior chamber of the eye, I have been able to produce a general miliary tuberculosis—the tubercles containing bacilli, and giving rise to tuberculosis by successive inoculations—in about twenty-five per cent of the cobayes and rabbits operated on. Shortly afterwards similar results were attained by Koch. My own experiments have since been repeated on a larger scale, and with commensurate success.

I next proceeded to inquire why the virus of lupus inoculated into the peritoneum and anterior chamber of the eye, should so frequently cause tuberculosis, while, if inserted in the usual manner beneath the skin, it seems unable to do so. An accident furnished me with what I believe to be the true explanation. In each of two cobayes—who failed to respond to peritoneal inoculation—the skin only having been sewed up, the morsel of lupus-matter had escaped from the cavity of the abdomen and lodged just under the skin between the incised muscles of the latter, along with a bit of ruptured epiploon with which it remained in close contact. Two months after the healing of the wound (which was completed in eight days) a flattened swelling about the size of a penny-piece arose at the inoculated point. This tumor finally ulcerated at the centre, the sore looking very like a superficially ulcerated scrofulous gumma of the integument. Sections of the same bore a striking histological resemblance to lupus-sections.

Since then, I have succeeded twice out of seven times in my endeavors to reproduce the above phenomenon by joining the bit of lupus-matter introduced under the skin to a shred of ruptured epiploon, for the purpose of affording it nourishment. In the successful cases the animals after death presented no other tubercular lesions than the swelling just described. All the facts, then, seem to prove that, by inoculating with lupus-matter under certain conditions, we can produce, at our pleasure, either a general or a local tuberculosis—that is, the latter will remain localized for a certain time, at least.

Micro-organisms of lupus. The joint investigations of Professor Corlil and myself, so far as they have yet proceeded, have not resulted in the discovery of any form of microbe belonging to this affection. Koch, however, has been more fortunate. He has detected bacilli in seven cases of lupus, has cultivated them, and has produced unmistakable general tuberculosis by inoculation with the culture-fluid. Should these results be confirmed by future researches, the question will be definitely settled.

Nevertheless, confining my reasoning to the facts which I have myself observed, either alone or in association with my colleague, I cannot avoid connecting this absence of bacilli in the cases we have studied, with the variable success of our inoculations. In the cases which “took,” the tubercles—contrary to what occurs in genuine tuberculosis—were comparatively slow in making their appearance after the performance of the operation. If, then, it seems likely, after what has been said, that lupus is a local tuberculosis, it must still be regarded as tuberculosis in a state of attenuation. May it not be that the negative peculiarities (so to speak) of lupus—its lack of bacilli, and the infrequency of its successful inoculations—are owing simply to its protracted duration, in which it resembles fibrous tubercle? In this latter structure we know that the bacilli of tuberculosis are very rarely found.

What, now, are we to conclude from the foregoing statements? Undeniably, clinical observations, pathological anatomy, and, above all, the results of experimentation, seem alike to testify that lupus is *frequently* a primary local tuberculosis of the skin or mucous membranes. But is this *invariably* the case? Is not

the affection sometimes *something else*? In other words, are its distinguished clinical features so clearly and accurately defined as to enable us to say of lupus vulgaris—that is, of *what we actually understand by that term*—that it is *always* a primary local tuberculosis of the skin? The question scarcely admits of a decisive answer. Who can venture to deny the possibility that under the name lupus vulgaris may be included *affections essentially and specifically distinct, however alike in their objective features*? General pathology is constantly presenting us with instances in which similar effects (or, at least, effects which *seem to us* similar) are produced by widely-differing causes. Thus, without adverting to the obsolete notion of a syphilitic lupus, we see various dermatologists, such as Hutchinson and E. Wilson, Fournier and Veiel, admitting the possible occurrence of lupus as a late manifestation of hereditary syphilis—a sort of degenerate luetic product that mimics the real scrofulo-tubercular lupus. Professor Fournier has informed me of a singular case bearing upon this very point. It is that of a priest on the staff of a well-known religious establishment, whose face was attacked by a lupus about as large as the palm of the hand. It presented, with its softened, semi-transparent, “barley-sugar” tubercles, a highly characteristic form of the disease. Fournier exhibited it to his hospital-colleagues as a typical case of lupus vulgaris, and there was no hesitation about the diagnosis. Nevertheless, Fournier, in order to satisfy his conscience, prescribed some iodide of potassium internally, without any local treatment whatever. In less than five weeks the lupus was completely cured. The priest had never had syphilis—in fact, Fournier was quite convinced, on various grounds, that he was a virgin. Was this an irregular variety of pseudo-lupus proceeding from tardily developed hereditary syphilis? There is another case of the same kind in the St. Louis Hospital, at this moment.

On the other hand, the objection will certainly be interposed by some dermatologists, including Vidal, that the fact of a resemblance between true cutaneous tuberculosis and lupus vulgaris is insufficient to prove the identity of the latter with the former. And, in fact, *it is, as yet, impossible to positively affirm this identity*. Perhaps future investigations, properly conducted, will enable us to decide the question by separating the lupus of Willan into several distinct diseases—and just as likely, they may serve only to establish its unity upon an unassailable basis.—H. LELOIR, *Le Progrès Médical*, Oct. 4, 1884.

LUPUS OF THE VULVO-ANAL REGION.

THIS undoubtedly rare disease was first described as a separate affection by Huguier, in 1848. He calls it *l'esthiomène*, and divides it into several sub-varieties, which are now by general consent contracted into two, viz., the superficial or serpiginous; 2. the hypertrophic. By West reference is made to five cases, and in Duncan and West to another case. The best account of the disease in the English language which I have been able to lay my hands upon is from the pen of Dr. Isaac E. Taylor, and is contained in Vol. VI. of the “*American Gynecological Transactions*,” p. 199. He gives an account of seven cases.

I have, myself, met with only three examples of true lupus in this situation, all of the hypertrophic variety. Of that very unsatisfactory class of cases sometimes called lupoid ulceration of the vulva—characterized by numerous tender, ulcerated, and painful spots near the vaginal orifice, which are difficult to heal, and very liable to return again after being apparently healed—I have seen a great many more than I care for, or have obtained much credit from.

As to the nature of lupus in general, it appears to be an affection of the true skin, whether originating in the cutis, in the rete Malpighii, or in the sweat-glands, characterized by a tendency to the formation of rounded points or tubercles, by proliferation of large, round cells in a matrix of soft connective tissue (some of the cells assuming giant proportions). These tubercles, which vary in size from that of a pea to a bean, as they increase in size break down by suppuration, and leave an angry ulcer, which tends to spread and has little inclination to heal, and is extremely liable to break out afresh after it seems to have been cured. Efforts have been made to connect lupus with certain cachectic conditions, such as syphilis and scrofula. It would appear, however, that it must be looked upon as a local and not a general affection, its origin having to be sought for in some local irritation. It is urged by Huguier, in explanation of the frequency of lupus in the face and vulvo-anal region, that anatomically and physiologically, these regions have very much in common. Of the condition as affecting the vulva, no better statement can be given than the following from Huguier's memoir:

"This chronic malady, which holds a middle position between the elephantiasis of the Arabs, syphilis, cancer, and scrofula, whilst it is not essentially of this last nature, is characterized by the leaden or violet tint of the parts, their disfigurement, induration, and engorgement, their ulceration, destruction, hypertrophy, and simultaneous infiltration, in such a manner that the orifices and canals presenting themselves in the vulvo-anal region may be at the same time ulcerated, enlarged, and contracted, their furrows and cutaneous furrows and foldings more developed, thickened, and the seat of ulcerations and cicatrices more or less extended and deep, without continuous or darting pains, without directly threatening life, or even for long without inducing a marked effect upon the constitution.

I am inclined to agree with Dr. Isaac E. Taylor in believing that the deformity and disfigurement resulting from the ulcerations and cicatricial contractions of a vulvo-anal lupus are greater and more disgusting than the corresponding changes which this disease effects on the face. The destruction of tissue is indeed sometimes terrible in its extent; yet there is an extraordinary disproportion between the feelings of pain and discomfort and the amount of ulceration and swelling. The ailment, while extremely chronic in its nature, is of a purely local and non-infecting character, never involving the inguinal or other glands. The entire ano-perineal region may be eaten away, the bowel being at one time contracted by the disease, at another dissected and left hanging out like the torn sleeve of a coat. As the affection creeps over the anterior edge of the perineum its tendency is to extend a small distance into the vagina, and in this situation the hypertrophy is not nearly so marked as when it passes anteriorly so as to invade the labia. The appearance posteriorly is that of a shallow ulcer, with edges very distinctly indurated, but not overhanging. Anteriorly, the ulceration burrows deeply below the tissues, and its edges are bounded by hypertrophied polypoid-looking masses of tissue invaded by lupoid elements.

Diagnosis.—The diagnosis of this affection is of very great importance, and requires careful consideration, as it is apt to be mistaken more especially for specific disease and for epithelioma. First to distinguish it from epithelioma of the vulva.

1. Epithelioma gives rise to a more stony hardness than lupus does, and is not accompanied by the peculiar tendency to hypertrophy of the adjoining tissue.

2. Epithelioma never forms an open sore for months and even years without infecting the glands in the neighborhood or inducing secondary malignant disease in some distant organ.

3. Besides, when epithelioma does ulcerate, it does not give rise to the deeply-excavated ulcers with overhanging edges which lupus does, but to a more shallow, although angry-looking surface.

4. It is seldom that epithelioma persists long in the vulva or elsewhere without giving rise to pain, especially of a lancinating character, and this is particularly not the case with lupus.

5. The microscope may be employed in case of doubt, when the portion removed, if from epithelioma, will show the characteristic cancer cells, whilst the lupus will exhibit lupoid tissue.

6. In a case of long-continued lupus, the fact of its prolonged duration, without deeply affecting the constitution, is itself conclusive evidence against the possibility of its being any form of malignant disease. But I believe the *greatest difficulty* is to get the medical adviser to think of lupus as a possibility.

From Syphilitic Ulceration.—The history of the case ought to be carefully scrutinized, and the possibility or probability of constitutional syphilis investigated. If the result is negative, it is in favor of the non-syphilitic character of the affection. M. Huguier enters at considerable length into this distinction. One may gather, I think, from his observations, that the surrounding hypertrophy, the depth and extent of the ulcerations, and a careful estimate of the history will usually suffice to separate lupus of the vulva from specific disease of that region.

The Prognosis is on the whole good.—Of Huguier's 9 patients, 3 were cured, 2 were relieved, 2 were not relieved, and 2 died. Of West's 5 cases, 1 was cured, 2 relieved, and 1 died under chloroform, and not as a result of the disease. Of Dr. Isaac E. Taylor's 7 cases, 2 were cured, 2 relieved, 2 not relieved, and 1 died. Of my 3 cases, 1 died of exhaustion after seven and one-half years of the disease, 2 were, so far as we can at present judge, cured.

Treatment.—In the milder, or what is called serpiginous form of this affection, the treatment to be adopted is of a simple character, so far as I can judge. If such cases came before me, I would endeavor to remove it by the administration of constitutional remedies, such as Donovan's solution, the application of mild, stimulating lotions, and the free use of scarifications, as practised by Vidal in Paris, the good results of which in facial lupus I have myself witnessed. But for the hypertrophic form, or cases in which there is much and deep ulceration, I do not hesitate to state that I regard the removal of the diseased structures as a necessary preliminary to successful treatment. Care must be taken in removing the disease in the posterior part of the vagina to avoid wounding the rectum. Consequently a different method must be adopted, according to the part of the surface we are dealing with. To meet this difficulty, I remove the hypertrophied and diseased-looking hard tissue posteriorly by knife, by scissors, or by gouge, according as I find one or other instrument the most suitable. I endeavor to arrest the bleeding points by touching the surface with a Paquelin's cautery at a dull-red heat. The base of the ulceration requires also to be freely touched with the cautery. The redundant hard tissues anteriorly in the region of the labia and clitoris, I prefer to dissect off with the Paquelin cautery knife. It does its work excellently, is free from subsequent pain, and effectually arrests hemorrhage. The raw wound is then treated like a granulating healing sore, with antiseptic

and non-irritating dressings. The patient is put upon arsenic or iron, or both, or other analeptic, according as such appears to be indicated. But, judging from two of my own cases, I find it hard to believe that constitutional cause has much to do with the production of the disease, and consequently also that it can be greatly alleviated by constitutional treatment.—ANGUS MACDONALD, *Edin. Med. Journal*, April, 1884.

GONORRHOËAL RHEUMATISM

This is an affection which arises in the course of a gonorrhœa, not by a mere coincidence, but as a special variety of rheumatism originating solely in the first-named malady. A patient who has been once attacked by gonorrhœal rheumatism will be likely, even after being thoroughly cured, to suffer in the same way again should he contract the infectious disease a second time. This rheumatism presents some peculiar features. In the first place, it is very seldom met with in females. Moreover, it possesses a remarkable affinity for the larger joints, such as those of the knee, elbow and hip, the small articulations being only secondarily involved. It is also usually confined to a single joint. Sometimes the articular affection is accompanied by extravasation and serous effusion; sometimes it is followed by ankylosis, which, through the rapid formation of fibrinous adhesions, may become hopelessly confirmed in the course of twelve or fifteen days. But gonorrhœal rheumatism may also invade other tissues. Thus: first, a joint may appear to be affected while it is the tendinous sheaths in its vicinity that are really involved, in which case we shall have a tendinous synovitis with swelling, and effusion. Second, the muscular system may be the point attacked, as evidenced by symptoms of the cervical muscles, of the deltoid, or even of the *motores oculi*. Third the afflicted parts may be the *bursæ mucosæ* of the elbow, knee and hip joints. Fourth, the sciatic nerve is not unfrequently attacked. Fifth, as was first remarked by M. Guyon, there may be œdema of the cellular tissue, with heat and pain. Sixth, the disease has been often known to seize upon several tissues at once in the same region.

Gonorrhœal rheumatism is also distinguished by the fact that it does not extend to the internal organs; the lungs and heart are never affected. It is of short duration and does not return, except after a fresh attack of gonorrhœa. A curious connection has been observed between gonorrhœal rheumatism and the urethral discharge—viz., that in some cases, though not always, where the latter is abundant, it diminishes after the appearance of the articular symptoms. This occurrence is still known by the old-fashioned designation of metastasis.

As to prognosis, the complaint in question is comparatively unimportant when involving only the tendinous sheaths—the *bursæ mucosæ*—or the muscles. But it is quite otherwise when the mischief is seated on a joint. Here the utmost vigilance is demanded, lest the process shall terminate in ankylosis. And whenever we are called upon to treat gonorrhœal rheumatism it should be our care first of all, to place and maintain the limb in the most favorable position, with a view to this unfortunate contingency. I recollect the case of a young woman who, having contracted gonorrhœa from her husband, and suffering from consequent rheumatism, had both her elbows immovably fixed in a most awkward fashion, her medical attendant failing entirely to recognize the real nature of the ailment. When summoned in his stead, I could only announce that the mischief was irreparable, except by a resort to osteoclasis or resection.

A stiff joint is one of the most frequent results of gonorrhœal rheumatism; it is

often accompanied by muscular atrophy, and lasts a long time. In such a case we should try to restore freedom of movement gently and by degrees, so as to avoid hardening and enlarging the fibrous tract. These troublesome conditions are best treated by electricity, massage, sulphur baths, and the waters of Aix.

Our general management of this disease must differ from that of ordinary rheumatism in which salicylate of soda is the sovereign remedy. Here this agent is without effect, and we have to fall back upon revulsive medication, especially blistering, repeated twice or thrice at intervals of two or three days. When there is much effusion into the cavity of a joint, we should not hesitate to puncture the latter, an excellent procedure, since it affords immediate exit to an amount of fluid which would require two or three weeks for its absorption. The operation should be performed with a flambée canula, which should be rapidly introduced, lest it carry with it septic particles from the atmosphere. The joint should then be firmly compressed, in order to prevent a return of the effusion.

Lastly, as gonorrhœal rheumatism is attended by a speedy lowering of the constitutional forces, a judicious use of tonics is advisable, and our most reliable agent in this class is the sulphate of quinine.—TERILLON, *Gaz. des. Hôp.*, Aug. 7, 1884.

ERUPTION CAUSED BY THE EXTERNAL APPLICATION OF IODOFORM.

THE author has observed, within a brief period, seven or eight instances in which the external employment of iodoform has occasioned an erythematous affection, characterized by the formation of small vesicles, and bearing a close resemblance to acute eczema.

The applications were followed in a few hours by a deep redness of the surfaces acted on, gradually fading towards its edges, and accompanied by violent burning itching. Soon after, vesicles filled with a clear fluid made their appearance, to be converted—according to their localities, and the accidents (as scratching, friction of the clothing, etc.) which befel them—either into moist, crusty elevations, or circumscribed pustular patches of an impetiginous character. The degree of development attained by the complaint depended, of course, upon the duration of the drug-action and the frequency of its repetition. The extent of surface affected, rather than the severity of the local manifestations, appeared to be chiefly influenced by these circumstances; even a single application sufficed to evoke the morbid process in all its intensity.

The disease in question, therefore, may be defined as an acute dermatitis, or, more precisely, as a specific medicinal exanthem, in whose production a constitutional predisposition, or an inborn idiosyncrasy, is largely concerned.

The same results were found to follow, without important modification, from the use of every kind of iodoform, and whatever chemical impurities the article might contain. The mode in which it was applied—whether as a powder or an ointment, in solutions of ether or collodion—was equally a matter of indifference. It was enough for this purpose if the smallest trace of iodoform was present with the vehicle. Yet no such effects were produced, even in the most susceptible subjects, by the *internal* administration of the drug.

This iodoform-eruption may in most respects be likened to the mercurial eczema which affects some persons after inunctions with ung. cinereum or ung. precipit. alb. On the other hand, it differs essentially from those cutaneous inflammations which so frequently result from the use of carbolic acid or corro-

sive sublimate as a dressing for wounds. These latter phenomena are, for the most part, entirely local; they show no tendency to rapid peripheral extension, and, above all, no peculiar predisposition on the part of the skin is required for their production. The iodoform affection possesses no special features by which it can be recognized at once without a knowledge of its exciting cause. But I believe it to be quite important in practice that the physician should be able to diagnosticate it promptly. Two of my patients had suffered for years from a tormenting eczema of the anus and perineum—not the chronic form of eczema with infiltration, but a frequently returning and peculiarly obstinate acute eruption. In both, the disease had been caused by the wearing of iodoform suppositories for the relief of rectal disorders. This fact being ascertained, their sufferings were easily ended. In two cases of females, similar eruptions broke out over the inner surface of the thighs, whenever iodoform had been applied to the vaginal orifice.

The worst case I have yet met with was that of a respected colleague and fellow-townsmen of my own. For many years this gentleman was afflicted with a chronic urticaria, whose frequent visitations, though sufficiently annoying, could yet be endured with patience. But to this was added, some months ago, an extensive eczematous eruption, the cause of which, and of its continual recurrence, we were wholly unable to discover, until, while treating an accidental injury to his foot, we found that our patient possessed an idiosyncrasy for iodoform, and that his more recent trouble was solely due to the direct action of that drug. Since which, he has avoided all contact with the obnoxious remedy, and his "eczema" has completely disappeared.

In the treatment of this complaint we rely principally upon cold fomentations, with a five-per-cent solution of acetate of alumina, or washings with a two-per-cent carbol-spiritus followed by sprinkling-powders. Of course, the patient must have nothing more to do with iodoform.—A. NEISSER, *Deutsche Med. Wochenschrift*, July 24, 1884.

MOLLUSCUM CONTAGIOSUM GIGANTEUM.

ONLY two cases of colossal molluscum contagiosum are known, that of Hebra and that of Ebert Virchow. The author describes a tumor extirpated October 10, 1881, by Prof. Nicolaysen. It came from an unmarried woman, fifty-six years old. It sprang from the right side of the occiput and had the size of two fists. Its surface was purple, uneven, bled easily, but was not, properly speaking, ulcerating. It was hard, with intervening softer parts. It was not movable. Along the posterior border of the mastoid process were found some swollen glands as large as beans. The patient did well and continued so, at latest accounts, six months after the operation.

Microscopical examination revealed that the tumor was composed of small lobules separated by thin septa of connective-tissue fibres. Each lobule was composed of cells of epidermal type. Nearest the periphery these were flat and horny: more internally, they contained protoplasm, and the centre was formed by the fatty or waxy, shining, round or oval bodies characteristic of molluscum. As in some of them a nucleus could still be made out, Laache supposes they are transformed cells.

Similar bodies have been found interspersed in small numbers in epitheliomas, but the large heaps formed exclusively by them, which appeared even macroscopically, by imparting a particular, paraffin-like shine to the cut surface, are characteristic of molluscum.—S. LAACHE, *Nordiskt Medicinskt Arkiv*, 1882, vol. xiv., No. 21.

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TWO CASES OF CHANCRE OF THE LIP.

BY

CHAS. W. ALLEN, M.D.,

New York.

ALTHOUGH, comparatively speaking, the initial lesion of syphilis is rarely found occupying the lip, it was recently my fortune to see two cases in one afternoon, at the University Dispensary, in which the chancre was thus situated.

Chancroid does not appear to be often seen in this location, but of the extra-genital true chancres, that of the lip occupies a prominent place, numerically as well as otherwise.

Fournier found twenty-six extra-genital chancres in a series of four hundred and seventy-one infecting sores observed by him. Nearly half of these were located on the lips. Of the extra-genital chancres recently reported in this country, the majority appear to have been situated in the region of the mouth.

Van Harlingen, of Philadelphia, published in the *Medical Times*, of Nov. 1, 1884, ten cases which had occurred in his practice, which is not a venereal one, from 1873 to 1883. Six of these we find were located on the lip, three of them having resulted from bites. In October, 1883, Bulkley published two cases of chancre of the lip, chosen from a large number or similar cases met with in his practice.

Having been Dr. Bulkley's assistant during the past two years at the New York Hospital, I know that extra-genital chancres are not rarely met with at his clinic.

In the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES of November, 1884, we find a résumé of Taylor's interesting article on chancre of the tonsil, three cases of which had fallen under his observation. The infecting chancre may occur on almost any region of the body. I have met with it on the breast, behind the ear, on the hand, the finger, the lip, and the cheek.

That on the cheek was an interesting case treated by me some three years ago at the North-Eastern Dispensary. The patient, an Irish laborer, had cut himself while shaving with a razor borrowed from a friend. The friend had an eruption on the face and body, and as far as I could gather a history, was suffering from syphilis. He promised to come and see me, but I was never able to verify the patient's statements about him.

I am now able to report two cases which I saw on December 3, 1884, in which well-marked chancres occupied the lower lip on the right side.

CASE I.—Frank L., U. S., æt. 22; single, ballet dancer. Has previously had venereal disease. Six weeks ago contracted a gonorrhœa which he has treated with *injection Brou*. There still remains a slight watery discharge. Since then has had no connection. Two weeks ago noticed a small hard lump on the right side of the lower lip which gradually increased in size until now it is as large as a Concord grape, markedly indurated and slightly ulcerated on the upper and mucous surfaces. The submaxillary and sublingual glands are enlarged and tender. The cervical, post-auricular, inguinal, and Sigmund's glands are all enlarged. The fauces are slightly inflamed.

There is no specific eruption on body, but a remarkable one-sided chloasma occupies the right side of the chest, reaching from the median line in front to the spinal column behind, and from the free border of the ribs to the axilla. The pigmentation is in small plaques except in the axillary region, where it resembles lentigo. The patient states that this condition has existed since birth. Although I had no idea of its being pityriasis versicolor, I took some scrapings from the patches and examined them. The result was negative. Ordered potass. chlorat. gr. v. thrice daily. Not wishing to use anti-syphilitic treatment until the eruption had been watched for, I gave a carbolic ointment to apply to the lip.

Dec. 10.—The surface of the chancre is covered with a yellowish-gray false membrane, hardness somewhat diminished, glandular enlargement about the same. No eruption. Treatment continued.

Dec. 11.—Patient called at my office stating that he had been summoned out of town by a theatrical engagement. Examination of body showed a faint, but characteristic macular syphilide. Ordered tablet

triturate of hydrarg. chl. corros. gr. $\frac{1}{20}$ three or four times daily, and to report upon his return to the city.

A specimen of the slight moisture at the meatus was examined for gonococci, but none were found, although pus-corpuscles were present.

CASE II.—Ida M., U. S., æt. 22, married.

Patient states that two months ago she "contracted a discharge" from her husband who appeared unwell and had a sore throat, and that she separated from him on this account.

Since leaving her husband, she says, she has not been exposed.

About one month ago, she burned her lip slightly with creasote while applying it to an aching tooth. Shortly after this she noticed a hard lump just where the burn had existed. This swelling had increased and hardened, until now it is ivory-like, and causes a projection and eversion of the lip. The inside of the lip is ulcerated over a surface the size of a cent. This ulcer has a dirty gray base and is surrounded by a dark-red areola. The tumor has a shiny surface and is of a purple-red color. Swelling of the submaxillary gland makes the neck quite prominent. The cervical and inguinal glands are enlarged, as are also the ante and post-auricular on the side opposite the chancre. The body, forehead, scalp, and extremities are the seat of a sparse papular and papulo-squamous syphilide which had been noticed a few days before. Over the chest are several circular, waxy papules with border more prominent than the centre, although umbilicated, which in my experience are found only as an occasional early eruption in syphilis. No soreness of throat, no falling of hair, but tenderness on pressure over breast-bone; ordered pil. hydrarg. protiod. gr. $\frac{1}{4}$, thrice daily.

Examination of the genitals showed a labial abscess and a yellowish vaginal discharge.

The abscess was opened and the pus examined. It contained a great abundance of micrococci, and various other bacteria. A specimen of the vaginal discharge showed myriads of diplococci, bacteria termo, rod-shaped and in chains, outside of pus cells were some groups of cocci, but none of the characteristic groupings of gonococci as found in gonorrhœa in the male.

On December 8, upon examining the genitals, a collection of mucus was noticed in the fossa navicularis and a specimen taken for examination. It contained spermatozoa in considerable numbers; two small groups of gonococci only were found in specimen, one in a pus cell and one just outside. The existence of spermatozoa in the specimen renders the girl's history rather untrustworthy. A specimen taken from the ulcerating surface of the chancre on Dec. 10 showed four or five pus-cells, each containing from four to thirty or forty micrococci, mostly in form of

diplococci or dumb-bells, but some resembling very closely the gonococci of Neisser. The chancre is now quite small, the ulceration has healed, the eruption has almost disappeared, but the glandular enlargements remain about the same.

The precise history of infection is wanting in these cases, but the diagnosis could be easily made from the appearance of the lesion. Other lesions for which it may be mistaken are epithelioma, chaneroid, traumatism, and in its early stages, simple fissure of the angle of the mouth, herpes labialis, etc. The striking facts that both these patients were of an equal age, lived in the same street (one East and the other West), and had presented themselves on the same day with almost identical lesions, led me to inquire carefully into their knowledge of each other. I was unable to establish any connection whatever between them.

In both cases, which are still under treatment, slight induration persists at the site of the primary lesion. In each there has been a papular eruption and other secondary manifestations. Case I. now has a few large flat papules scattered over the trunk and arms. There still exists in this case a watery urethral discharge. Although no gonococci were previously found, I have since discovered them in epithelial scales scraped from within the meatus.

102 EAST 57TH STREET, Feb. 13, 1885.

A CASE OF ERYTHEMA NODOSUM COMPLICATED WITH SYPHILIS.

BY

E. C. VIDAL, M.D.,

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JUNE 21, 1884, I was called to see a woman, about forty years old, suffering with an eruption and swelling of the ankles and feet. This latter was so great that locomotion was interfered with.

The eruption had made its appearance about thirty hours before I was called, having been preceded, the evening before, by a swelling of the ankles. It appeared in the form of a confluent efflorescence on the ankles, presenting a dark-red hue. The dorsal surface of the feet pitted exceedingly, as did also the ankles, the left more so than the right. There was likewise a great deal of pain. Above this efflorescence, disseminated over the legs as high as the knees, there was observed a number of maculæ, ranging in size from that of a lentil to that of a large pea, of various shades of red and yellow, which retained their color under pressure of the finger. In addition to these were a few round papules, varying

from a pea to a small cherry in size, which were dark blue or purple in color, and excessively painful upon pressure. The right leg was so painful that the patient could not sleep. I found the hands and feet cold and moist, while the remainder of the body was warm.

When first attacked, there was fever, but no headache ; appetite was good, and the bowels were regular.

I prescribed the horizontal position, tonics, applications of cold water to which tinct. opii was added, to the ankles and feet, and prohibited all alcoholic drinks, to which the patient was addicted. Under this treatment, the eruption gradually disappeared.

June 24, there was little alteration in the amount of œdema ; the pain had been so intense that there had been no sleep obtained during the previous night. From this date the swelling diminished, and the eruption continued to fade away. The largest of the papular eruption disappeared by gradual depression in the centre, and were covered by a hemorrhagic crust. The smaller ones slowly sank below the cutaneous surface, leaving behind a yellowish scale which was readily removed intact, exposing a surface simulating, in color, smoked beef. The pain continued *very* severe on the right side of the right foot, which was the seat of a group of four small tumors, about the size of a bean. The crusts covering these, as well as those on the left foot, which was similarly affected, were removed by the water dressings, and exposed an ulcerous sore about a millimetre in depth.

July 12, the œdema had almost entirely disappeared, and on the right ankle there was extensive desquamation. The sores were healing slowly under a treatment of pulv. iodoform, but there was no abatement in the degree of pain. I now discovered, upon the face, a papular eruption which had appeared since my former visit, the week before. These papules, several in number and as large as a pea, bore the same species of scale, readily removed, exposing the same brownish-red base as above described. On the inner surface of the right leg, near the knee, was an egg-shaped tumor about the size of a walnut, of a purple color, and *exceedingly* painful when touched, its immediate neighborhood being inflamed. It first appeared on the 8th, to partially disappear on the 10th, and then again assume its first dimensions when I saw it. Its longitudinal diameter was directed with the axis of the leg. The appetite had become almost null, and it was found necessary to keep the bowels open with saline cathartics. There was no febrile disturbance.

I would state that I had been treating the patient with pot. iod. for some time, but with no apparent effect.

On 19th, the eruption had extended to the scalp and on the arms ; there was also alopecia. The throat and mouth were in no wise affected ;

there was no headache. On examination, I could discover no primary lesion, and no specific history could be obtained.

I now ordered the "mixed treatment," under which the eruption began to fade away; the swelling of the left ankle disappeared entirely, that of the right to a less extent and much more slowly, and the ulcers healed. About this time I presented the woman to Professor Piffard, who confirmed my diagnosis of the later manifestations, by declaring it a case of late syphilis.

ON VARIOUS METHODS OF TREATING LUPUS VULGARIS, INCLUDING THE USE OF BURR AND HOOK.

BY

GEORGE HENRY FOX, M.D.,

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THE removal of lupus by the knife may be considered as obsolete.

It is only a short time since this was the chief method in vogue, but it has been superseded in recent years by a number of greatly superior methods of treatment. That excision is effective in removing a small patch of lupus no one will deny; but as our aim should always be, firstly, to remove the disease, and secondly, to leave as slight a scar as possible, the loss of healthy tissue, resulting from the use of a knife, is an insuperable objection to any cutting operation. •

The use of the galvanic or thermic cautery is equally objectionable. If sufficient heat is employed to completely destroy the morbid growth, and not merely enough to temporarily cicatrize the surface, there must necessarily be a considerable destruction of healthy tissue and the production of a dense and contractile cicatrix. I have seen a most brilliant result follow the application of the actual cautery in a case of lupus of the cheek, and six months later I have seen the lupus nodules springing up all over the smooth, cicatricial surface. I believe the action of the actual cautery in lupus to be delusive, and in spite of the able advocacy of this method of treatment in recent years, am disposed to utterly condemn it.

The various potential caustics which have been employed with greater or less benefit in this disease are only of service, as a rule, after the disease has ulcerated, or the greater portion of the morbid mass has been scraped away. Chloride of zinc, caustic potash, ethylate of sodium, etc., I have applied after the use of the curette, and although they have evidently lessened the tendency of the disease to return, they have not tended to improve the character of the resulting cicatrix, and hence are

not to be recommended. There are, however, two caustics which may be advantageously used, as they are not liable to destroy the healthy skin to any extent. These are nitrate of silver and arsenic. With a sharp cone of nitrate of silver, large, deep-seated, and isolated nodules of lupus can be bored out and destroyed with greater ease and certainty than with a curette. - Where isolated nodules are numerous, an arsenical paste (arsenious acid one part, pulv. acacia two parts) may be applied to a square inch or more of surface with the effect of destroying only the diseased tissue.

In certain cases of lupus vulgaris the dermal curette is almost indispensable. Where the disease has existed for a long time, and involved the entire skin of the affected patch, and perhaps become ulcerated, the mass of soft morbid tissue can be more quickly and readily removed with the curette than by any other means. But one curetting, if not followed by a thorough cauterization of the raw surface, is not likely to effect a cure, and very soon a reappearance of the disease becomes manifest at various points in the form of small, brownish-red nodules. Under such circumstances the use of the instruments to be presently described will be found extremely advantageous.

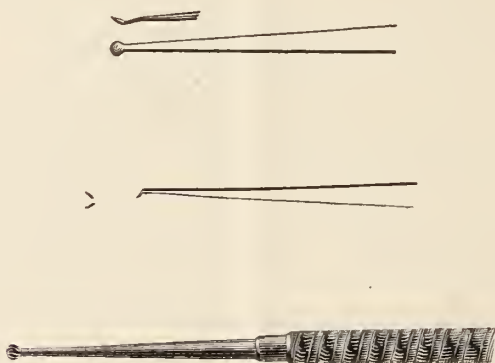
Linear scarification, as recommended by Squire and Vidal, is a slow method of destroying patches of lupus, but in many cases it is undoubtedly the very best plan that can be adopted. The rapid removal of an extensive patch of lupus by the curette leaves a large ulcerated surface, and later a contractile, and often a disfiguring cicatrix. In certain localities this is a matter of little or no consequence, but when the disease is seated upon the nose or near the eyelids, the avoidance of a deforming scar is quite as essential as the destruction of the morbid growth. Linear scarification, if skilfully performed, destroys the lupus cells or sets up an inflammatory process which favors their absorption, and the loss of substance is gradually replaced by a new growth of connective tissue. This plan of treatment is therefore of the highest cosmetic value, and should be invariably employed in every case where loss of tissue is particularly undesirable. An ulcerative lupus of the nose which bids fair to destroy the greater portion of the organ, and which would certainly leave it in an unsightly condition if treated by the curette or caustics, may be successfully treated by scarification, and with a result which is often as astonishing as it is satisfactory.

The foregoing are the established methods of treating a disease which is often obstinate, but never incurable. I desire now to briefly call attention to another plan of treatment, or, at least, to certain instruments which I have found extremely serviceable in the treatment of lupus vulgaris. These instruments are in common use by dentists for the purpose of boring and excavating cavities in the teeth, and nearly every

reader has doubtless had occasion to become painfully familiar with them. Indeed, it was while reclining in a dental chair, and nervously regarding these dread instruments, that the idea first occurred to me that they might be advantageously employed in boring into and excavating the nodules and small deposits of lupus tissue. I have since used them in a number of cases. In a certain condition of the skin, particularly that following other plans of treatment, I regard them as almost indispensable in completing the removal of the disease.

The burr, a steel bulb with coarse or fine threads, may be used of any size from a pin's head to a large pea. Attached to a dental engine or electro-motor, the revolution of the burr may be made so rapid that it will quickly effect the desired destruction of tissue; but for all practical purposes it can be inserted in the handle shown in the illustration, and rolled backward and forward between the thumb and finger while it is gently pressed into the diseased skin. For the removal of large masses of lupus tissue it is not as useful an instrument as the curette, but for isolated nodules it is preferable, while for the removal of very small and deep nodules a small-sized burr is decidedly more useful than a small curette.

The hooked instrument is of service when the greater portion of



the lupus tissue has been destroyed, and there is nothing remaining but small brownish-red points of a pin's head size. Where the lines of searification have crossed and formed a cicatricial network with rectangular meshes, a few lupus cells are often left in the interstices, and, multiplying, as they usually do in a short time, appear as brownish-red spots. In such a condition of the skin the hook will accomplish what no other instrument is capable of doing. The point of the hook is readily inserted into the dark and yielding speck, and a few revolutions or half turns of the

handle, held perpendicularly or at an angle with the surface of the skin, will quickly destroy the small mass of diseased cells which would otherwise serve as a starting-point for a fresh growth. After the use of the hook I have sometimes thought it advisable to introduce into the cavity the point of a tooth-pick dipped in carbolic acid.

A variety of excavators, differing in size and shape, are used by dentists, and any one may be selected which fancy or experience may suggest. I would urge a trial of the burr and hook, and am certain that in other hands they will prove as useful and, indeed, as indispensable as they have in my own.

TINEA VERSICOLOR OF THE FACE.

BY

C. M. G. BIART, M.D.,

Omaha, Nebraska.

IN the limited amount of literature at my command bearing upon the subject, I fail to find recorded a single case of *tinea versicolor* occurring on the face.

Duhring, in his treatise on "Diseases of the Skin," p. 591, says: "It is never encountered on the scalp or face." Liveing, "Diagnosis of Skin Diseases," p. 190, "Pityriasis versicolor is most common on the trunk, and does not attack the forehead and face, the common localities for *chloasma*." Other authors consulted make similar statements. Morris, "Diseases of the Skin," p. 310, however, states that, "It rarely affects the scalp and face." Hence he admits the possibility of its occurrence in that region, but does not distinctly state that such cases have come under his observation, which would be necessary to positively invalidate the contrary statements of the first-named authors.

Considering the extreme rarity of the occurrence of *tinea versicolor* about the face, the following case may not prove uninteresting:

Ed. C., æt. 31; driver; is a very robust man. He consulted me on July 6, 1884, for a brown discoloration existing on his face. According to his statement, it was spreading rapidly, and he applied for relief merely on account of the resulting disfigurement, as it caused him no other annoyance. He also stated that a similar condition had been present on his body for several years.

On examination, I found a very dark-brown discoloration covering almost uniformly the back and chest, down to a line on a level with the

umbilicus. It extended, also, on the arms; on the right one to just a little beyond the elbow, but on the left arm not quite reaching that articulation. About the shoulders there was more or less irritation, giving the diseased surface in that region a reddish appearance. There was scarcely any desquamation noticeable, the patient perspiring quite freely. A number of variously sized brownish spots encircled the neck, and underneath the lobe of the left ear could be seen a spot the size of a silver half-dollar. Several spots, from the size of a pea to that of a finger nail, were noticed on the left cheek up to the external canthus of the eye. On the forehead, the discoloration, which was very dark, extended from the left temporal region to the middle of the right supercilium, forming a continuous band, irregular in outline. At its broadest part, situated in the left temporal region, it encroached somewhat upon the scalp, following closely the line of the left eyebrow for three-quarters of its length, then narrowing from above and below, terminating in a rather broad point. Here a few detached pea-sized spots were visible.

A microscopical examination of a few scales, scraped from the diseased surface on the trunk, revealed, as I expected, the presence of the fungus *microsporon furfur*. Scales obtained from the patch on the forehead also showed the fungus in abundance. These latter scales were collected and removed with a fresh blade, only after previous ablution of the hands, a new slide receiving them. Still somewhat skeptical, and to obviate all possible source of error, I first proceeded to cure the disease present on the trunk. This result attained, a few scales from the discoloration on the forehead were again obtained, and examined under the microscope, and again the presence of the fungus demonstrated. This placed the diagnosis of "tinea versicolor of the face" beyond a doubt, and the disease in this region was subsequently removed by appropriate treatment.

STRICTURE OF THE URETHRA.¹

BY

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IN opening the discussion of the evening, I shall confine myself to the advancing of certain propositions, and to the presentation of certain instruments, to facilitate the diagnosis, and treatment (by dilatation) of stricture of the urethra. I may be over-zealous in my position, but my convictions are strong that the portion of the urethral

¹ Read before the New York Dermatological Society, Jan. 27, 1885.

canal interiorly to the triangular ligament is too often subjected to the unnecessary and harmful introduction of instruments. I refer to the prevailing use of the curved steel sound as taught in surgical textbooks and by professors of surgery, and as practised by the profession at large. Knowing that the membership of our Society includes some of the leading genito-urinary specialists, I have taken this opportunity to present the subject.

I would be understood to limit the discussion to stricture consecutive to gonorrhœal urethritis. I would also be understood, when I say "stricture consecutive to a gonorrhœal urethritis," that the gonorrhœa has been the exciting cause which has led to the development of the condition of obstruction, which demands treatment; that I recognize the possible existence of points of narrowing in a urethral canal previous to the occurrence of a gonorrhœa—such narrowings, however, not calling for surgical interference; and that where such narrowings exist, they are the vulnerable points at which a gonorrhœal urethritis produces the tissue changes which constitute the stricture lesion.

1st. That stricture consecutive to a gonorrhœal urethritis is located, as a rule, in the portion of the urethra which is exteriorly to the triangular ligament.

The only positive, practical, and reliable data upon which to establish the *locale* of stricture, from this or any other cause, are to be derived from direct measurements, in living cases, with instruments devised to be introduced into the urethral canal; hence the value of Otis' and Gross' tables of cases.

From Otis' 227 cases (see "Stricture of the Male Urethra" by Fessenden N. Otis, M.D.) of stricture consecutive to gonorrhœal urethritis, 202 or 89 per cent were located exteriorly to the triangular ligament or within six inches of the meatus; and 11 per cent interiorly thereto, or interiorly to six inches from the meatus.

2d. In 89 per cent of cases of stricture from this cause, the passage of an instrument interiorly to the triangular ligament, and into the bladder, is calculated to produce needless pain and avoidable complications.

I need not here allude to the urethral, epididymal, vesical, renal, and constitutional disturbances which may, and not unfrequently do, follow the use of the curved sound, as passed into the bladder for purposes of diagnosis and treatment. Even in skilled hands, the passage of a sound interiorly to the triangular ligament is a surgical manipulation which requires great care and judgment.

I would have it stated, as an *axiom of practice*, by writers on general surgery, by specialists in genito-urinary diseases, and by professors and lecturers, that a stricture or strictures having been located

exteriorly to the triangular ligament, no instrument should be passed, for its treatment, interiorly to the ligament.

3d. *In expressing the location of a stricture of the urethra, the following terms: "penile portion, spongy portion, bulb, bulbo-membranous portion, bulbo-membranous junction, membranous portion," lead to a great deal of misunderstanding. It would be well to use, instead of them, the following: "exteriorly to the triangular ligament, at so many inches from the meatus; and interiorly to the triangular ligament, at so many inches from the meatus."*

The locating a stricture, according as to whether it is exteriorly or interiorly to the triangular ligament, commends itself as an anatomical and appreciable dividing line for classification; it is also calculated to afford precise indications as to etiology, and the selection of methods of treatment.

4th. *It is important to obtain the relations of the dimensions of the penis to the urethra, as follows: 1. The circumference of the body of the penis in the flaccid state; 2. The length of the dorsal surface of the flaccid penis; 3. The calibre of the meatus; 4. The length of the urethra from the meatus to the triangular ligament.*

The first steps in this anatomical direction have been made by Otis, in his recognition of the normal relation of the circumference of the body of the flaccid penis to the normal calibre of the urethra.

I take pleasure in presenting for your inspection the following instruments, which have afforded me great satisfaction:

1. *The penismeter* for obtaining the circumference of the body of the flaccid penis. It consists of a metal tape which is ruled for five inches of its length; it is made to play in a circle—one end perforating the other—so as to adapt itself to any required circumference.

2. *A set of meatometers*, to ascertain the calibre of the meatus. These are short tapering sounds, three quarters of an inch long, spaced off, and the spaces varying from 20 to 32 mms. in circumference (French scale); each instrument represents four or five sizes. They are modifications of Piffard's meatometers, the latter being so long as to be often arrested by a stricture near the meatus.

3. *A set of metal bougies à boules with non-flexible ruled staffs.*

4. *A set of urethral sounds with ruled staffs.*

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

151ST REGULAR MEETING, JAN'Y 27, 1885.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. BRONSON presented

A CASE FOR DIAGNOSIS.

Rosa S., 7 years old. At birth she appeared perfectly healthy and remained so until three years of age, when she had inflammation of the brain with much fever, to subdue which cold applications were made to the head. Shortly after this she had diphtheria, which lasted several days. Some time after it was noticed that she had become deaf. Two years ago, having meantime been perfectly well, except the deafness, an eruption appeared on the face. Shortly after, it was discovered one morning that the skin was covered with red spots, mostly on the legs, buttocks, and arms, less on the body. The eruption was the same as at present excepting that it was redder and the spots larger. One year ago, the patches on the legs and arms began to ulcerate. Her mother says that several spots would run together and form ulcers. About the same time she had ulceration in the mouth, and the jaw could not be opened. Occasionally she has suddenly marked swellings of the hands, feet or knees, which quickly disappear upon pressure; the skin over them is not reddened.

At present, over the cheeks and chin, are a number of irregularly distributed brownish-red papules, varying in size from a pin's head to a split pea, elevated and hard, evidently due to infiltration. There is no affection of the epidermis. The color is of a brighter red in the newer, and darker in the older papules, and leaves dark pigmented stains. On pressure the color does not disappear. On the arms, legs, thighs, and buttocks is a similar eruption. The body, neck, and scalp are free. On the legs, and here and there on the arms, are many depressed roundish or oval cicatrices. There are three or four spots of ulceration, covered by dirty, hard, blackish crusts; underneath the latter the surface is red and bleeds easily. There is no infiltration of the border of the lesion. None of the patches are kidney or serpiginous shaped. The mouth can only be opened one-quarter or one-half an inch because of the adhesion of the chin to the gums, caused by the cicatricial tissue. There are no other cicatrices to be seen in the throat or mouth. No marked adenopathies.

DR. FOX showed two cases of

LUPUS VULGARIS.

Lizzie M., 28 years old; single. Nineteen years ago, the patient had an abscess in the right groin, the present disease extending from the abscess down the legs gradually spreading for twelve years and then ceased in this portion of the body. The eruption appeared eleven years ago as a small pimple over the right eyebrow. Taking this as a point of departure, it has extended over the whole of the right side of the face, involving the nose, upper lip, and the entire tempora-malar region. The chin has small pea-sized and slightly elevated papules, flat and scaly on the surface. The lesion presents the appearance of a red patch, dotted and splashed

with livid-colored interspaces, the whole covered with white, thin scales. The right upper eyelid at the external canthus is drawn outwards and upwards. There is also a small patch of eruption, about four or five inches in diameter, on the right breast, which has been present for the past eight years. All the right thigh, as far as the leg, is involved, also both gluteal regions. Some portions of the skin very greatly resemble ichthyosis.

The second case was that of a woman, 26 years old, who has had the eruption for the last three years. The disease commenced in three separate spots on the right cheek and three other spots at the angle of the mouth on the right side.

At present the lesion occupies both sides of the nose, right cheek, and nostril.

Dr. Fox presented these cases to show the benefit under treatment by means of the dental hook and burr, both of which had been used by him very much during the year past. The dental hook, such as is used by dentists in their operations, is used for the smaller miliary tubercles, the skin being easily punctured and the mass broken up and destroyed. It is simply a modification of the treatment by means of scarification. The dental burr is used for the larger nodules. Afterward the diseased portions are cauterized with nitrate of silver, also carbolic acid.

Dr. Fox then exhibited a case of

EPITHELIOMA.

A. H., 56 years old ; farmer. The disease commenced sixteen years ago on the left side of the bridge of the nose, as a small white blister with considerable scabbing. It gradually spread until it occupied its present position. Now all the nose except the tip, all the left side of the face beneath the eye, also the right side of the face, half-way across the cheek, are occupied by a red, granular, and bleeding mass. He gives no history of syphilis. His treatment, since he has been under Dr. Fox's care, has been chiefly local. The case was shown in order to obtain a prognosis.

Dr. BRONSON afterward presented a

CASE FOR DIAGNOSIS.

M. C., 15 years old. The patient is thin and anæmic, with an aged-looking face. He has dark eyes and hair and is somewhat freckled. His teeth are in good condition. He first noticed small pimples on the chest which itched ; these gradually increased and lately have been disappearing.

At present, on the lower two-thirds of the trunk and on the arms and thighs to a less extent, is a very abundant red or rose-colored papular eruption, clustered in groups (corymbiform), most of the groups being nummular, many of the papules are most marked at the periphery, while the centres show brownish staining. There is no fluid exudation. Many papules have adherent scales or scratch marks at their summits. In size they vary from a millet-seed to a lentil. At certain points, as the upper part of the arm, the skin is rough, dry, dusky-red, and slightly scaly, with an eczematous appearance. Itching is now moderate, but has been severe. There is some enlargement of the inguinal and cervical glands. No lesions on the penis or mucous membranes. The eruption looks very much like a miliary syphilide, but the larger papules are more rosy in color. There is also some flattening of the surface of the smaller papules.

Dr. ROBINSON showed a case of

PSORIASIS INVOLVING THE PALMS.

Jas. H., 30 years. Has had the present eruption for six or eight years. He now has a general eruption of characteristic psoriasis all over the body and extremities. In some places the lesion presents a pustular appearance. The interesting feature in the case is that the palms of the hands are affected with a dry and scaly eruption, which is undoubtedly a psoriasis. The backs of the hands are also affected. All the patches are of a dusky hue and sharply defined. There is no history of psoriasis in other members of the family. For the past two and a half weeks the patient has been taking acetate of potash and Fowler's solution, with the effect of causing the eruption to slightly fade.

DR. FOX presented a

CASE FOR DIAGNOSIS.

A man, 25 years old. He has had the eruption for the past ten days, confined to the chest and abdomen, also slightly on the back. It consists of very small fine points, which do not disappear on pressure. There is no itching. The patient's general health is good. The lesion has many of the characters of both purpura and acne.

DR. WEISSE then read the paper of the evening on

STRICTURE OF THE URETHRA.¹

In opening the discussion, DR. KEYES said that he never cut the meatus unless it was unnecessarily small. Every now and then he is asked to divide the meatus, and he invariably declines unless the patient has definite functional or other symptoms, which might be accounted for by the contracted meatus. The latter condition alone, without symptoms, is not, in his opinion, worthy of surgical interference, simply because it is small. In dividing the meatus for the sake of experimenting, he had always been disappointed in the result. A striking case was mentioned occurring in a reporter who had exciting work, and who was suffering from what is generally known as neuralgia of the neck of the bladder. He had never had syphilis or gonorrhoea, but his urethra was in an extremely sensitive condition. The meatus was small, and Dr. Keyes thought that this would be a promising case for division. The operation was performed, with the result of developing an inflammatory condition of the surface and an increased sensitiveness of the urethra. Anodynes were necessary to relieve the pain and irritation. This was but one of many cases. In his hands the operation was generally unsatisfactory in relieving spasm. This was not so, however, when the orifice was contracted to a small pin-head size, or where there was closure caused by the cicatrix of a chancre, then considerable relief would be afforded by division. But where the orifice would admit of an English twelve sound, he did not think that there would be any benefit. He believed that the instruments shown by Dr. Weisse were eminently suitable for the purposes for which they were designed, the only objection being the number of bulbs required to be introduced, which would cause unnecessary friction. He thought Otis' urethrotome preferable. He did not think that it was necessary to do anything when there was only moderate tightening from causes not traumatic.

DR. OTIS said that he was very much interested in the paper, and thought that the suggestions were exceedingly important, especially those in reference to the harm done by instruments being carelessly passed into the bladder. Scarcely a day elapses in which he does not see bad results follow the unnecessary passage of instruments. Cases of epididymitis were of frequent occurrence from this cause. He cited an instance which he had seen two days ago in whom the spermatozoa were entirely absent, and this resulted from the unskilful passage of sounds. He considered the instruments devised by Dr. Weisse were extremely ingenious. We commonly find strictures of the urethra just within the orifice, and

¹ See page 74 of this issue.

that these are likely to be causes of reflex troubles. He did not think it necessary to enter into a discussion of the value and importance of restoring the calibre of the meatus to that of the urethra. When we find contraction, however slight, there are apt to be reflex troubles, and the urethra should be divided, so that there will be no point of friction when the canal contracts. He finds in these cases that after cutting the urine passes more freely, although the patient was not aware of any contraction before. He had seen cases of Bright's disease where there was considerable pain in the back, which were relieved by dividing the meatus. We may consider the meatus in a pathological state even not when very small. He thought Dr. Keyes was unsuccessful because he did not pay sufficient attention to the matter of rest after the operation. He (Dr. Otis) never divided a meatus unless the patient could be put to bed and kept there a week under the care of a nurse. This was done because of the hemorrhage that was apt to follow, and also because the healing process would set in sooner. The division was made so as to go through the thickened to the soft tissues, and sometimes it was difficult not to make a hypospadias. The instruments were then introduced every day until healing took place, and if there were recontraction he again divided. Dr. Otis referred to the case of a prominent medical man who had an enlarged prostate, pain over the pubes, headaches, and other pains not commonly met with in prostatic disease. The orifice was contracted down to twenty-three or twenty-four, which he divided up to thirty-four. He received a letter from the patient a few days ago, stating that the greatest comfort followed the operation, in fact, a change from a state of misery to one of happiness. He was confident that the change was due to the operation. Thompson and others say that these conditions, viz., indefinite pains in the region of the back and bladder, can be relieved by division of the urethra.

Another case was that of a patient, F. H. B., who had been suffering from a gleety discharge for nearly two years. He was operated upon July 1st, 1873. He had a meatus through which a twenty-four sound could be passed three-quarters of an inch, where there was a stricture; another existing at one and a half inches, which admitted a twenty-two sound. The stricture was cut to thirty, and the sound could be passed through the entire canal. August 29th, a twenty-six sound caught slightly at one inch, and a twenty-nine resisted firmly at one and an eighth of an inch. These points were divided and a thirty again passed. It was subsequently dilated to thirty-one. The discharge continued up to Oct. 10th. Up to Dec. 6th the stricture was dilated to thirty-three, the discharge still continuing. A thirty-three bulb shows a stricture one and one-quarter inches from the orifice, and a half an inch in length, also another at two inches. These were divided with a dilating urethrotome. On January 7th the discharge still continued, and a recontraction was discovered at the site of the former stricture. This was divided to thirty-six. Jan. 27th and 29th, a stricture at one and seven-eighths of an inch was divided up to forty. The patient was under observation for a year, and there was no contraction. Dr. Otis said that the patient came to his office a short time ago and said that he had had no difficulty from his former stricture up to the present time, a period of eleven years. He has been married several years and has children.

Within the last few weeks Dr. Otis had seen two patients whom he had operated upon, and who were free from stricture, although the operation had been performed some years ago. He mentioned these instances to show the advantage of complete division of the stricture.

DR. SHERWELL asked as to the advisability of dividing or dilating a stricture three inches from the orifice.

DR. KEYES said when a patient presented himself with a discharge from the urethra, it was his custom to ascertain from what portion of the canal it came. If the anterior portion of the urethra, there would be a speck of blood or a shred of pus on the bulb; if it is deeper, this could be determined by the surface sensitiveness and threads of mucus, or the quantity of blood, when an instrument passed the tender point. So far as he knew and believed, there was always a tight place between two and four inches from the orifice accompanied by tenderness, because the canal is smaller there. He did not cut unless the narrowing were nodular or immoderately small. He thought that the majority of cases would get well by means of dilatation and injections. A certain percentage of cases do not improve either by the use of injections,

anterior or deep, or by dilatation. If in five or six weeks there is no benefit, then, unless there is some diathetic condition present to contra-indicate the operation, he divides the stricture, because a greater amount of pressure can be exerted in passing large sounds, thus squeezing all the blood out of the velvety tissue and producing a greater activity of the circulation. A satisfactory result is effected directly by the cutting and indirectly by the passage of the instruments. He did not believe that the discharge could be cured by cutting alone if large sounds were not passed. He has seen the discharge continue even when the urethra had attained an abnormal size. In some cases he had seen the patient get well when there was an improvement in health, even when the urethra remained contracted.

DR. OTIS did not at all agree with Dr. Keyes. He did not generally find the contraction two or three inches from the orifice, it generally existed in the penoscrotal region, to a greater or lesser extent in the majority of adults. He did not really see how Dr. Keyes' view was the correct one, as a very great amount of pressure could not be brought to bear by the passage of large sounds. Another point to be borne in mind is that the patients do not come back again, unless they propose to get married and then they wish to have the discharge stopped. He always has set it down as a rule that where there is a gleet discharge a stricture remains and he would be in favor of dividing at once, without putting the patient through a system of instrumentation.

DR. KEYES said that he wished to correct a wrong impression; he did not aim to cure the supposed stricture when slight tightening existed at a distance of two and a half or three inches, as is the case in a majority of persons, he only attempted to cure the gleet discharge.

DR. OTIS believes that every localized narrowing of the urethra is pathological, except in boys under puberty, who do not have stricture unless they have masturbated. He mentioned the case of a boy the calibre of whose urethra was only two-thirds of its normal size.

DR. SHERWELL referred to a case of acne caused, as he believed, by a stricture. He treated the stricture by dilatation and had passed a sound up to fourteen six times; at first, a thirteen could with difficulty be passed. The acne as well as the stricture was improving under this treatment.

DR. A. S. HUNTER (by invitation) thought the instruments filled a want which had long been felt. He was heartily in favor of not introducing instruments beyond the triangular ligament. He was also pleased because the instruments were not pointed.

DR. WEISSE, in concluding, said that he did not mention anything about cutting the meatus. He was very greatly pleased that Dr. Otis had established the relation of the circumference of the penis to that of the urethra. The one hundred cases which Dr. Otis had examined in reference to this point were of very great benefit in determining the pathological condition of the urethra. Eighty per cent of the strictures were due to gonorrhœa, and if ninety-two per cent of these were anterior to the triangular ligament, and if instruments ought not as a rule be passed beyond the ligament because of the bad results which follow, such as epididymitis, how necessary was it then to have instruments of precision to determine the exact site of the narrowing! Reference was also made to dilatation and pressure which were alluded to by Dr. Keyes; by means of these instruments, the exact point could be ascertained where pressure ought to be applied. Besides, they can be used with safety, as they cannot be passed beyond the triangular ligament. He wished to establish the fact that the majority of cases of stricture existed anterior to the triangular ligament.

Selections.

AN UNDESCRIBED FORM OF STRICTURE AT THE ORIFICE OF THE MALE URETHRA.

IN none of the works on surgery, general or special, which I have consulted, can I find any reference to the form of stricture which I here wish to describe. Apart from its rarity, the condition warrants a special description on account of the troubles it gives rise to and its resistance to treatment. In fact, I have met with no strictures of the urethra which gave both the patient and myself so much trouble as the two cases I have to relate. Indeed, I may say that, as compared with ordinary strictures of the urethra, the treatment of this form has been in my hands complete failure.

The first case was sent me by Mr. Skelton, of Downend. The patient was a strong, healthy laboring man, aged thirty-four, married, with children. He had never had any venereal disease, and no rashes, sores, or any irritative lesion on the glans or prepuce. During all his life, and for the first few years of his married life, he had been able to retract the foreskin completely and without difficulty. Within the past two years the foreskin had become adherent to the glans in a semi-retracted position, as the foreskin usually lay. At the same time the exposed portion of the glans became covered with a hard semi-cartilaginous tissue, which extended into the orifice of the urethra and caused narrowing of the canal. So much had this narrowing proceeded that when I saw him he was able only after violent expulsive efforts to propel the water in a tiny stream. Usually the water came only in drops, and micturition was always attended with great pain.

On examination, the whole of the mucous membrane of the glans penis almost up to the corona was replaced by a dense gristly material, so unyielding as to altogether prevent enlargement during erection. The exposed frenum was greatly enlarged and thickened. Behind the corona a probe, pushed through the adhesion between prepuce and glans, could be moved all round the penis. The meatus was contracted to a pin-point, admitting with difficulty an ordinary surgical probe, and was surrounded with the same dense, unyielding, gristly material. The contraction seemed to extend about a third of an inch down the urethra.

I divided the adhesions between glans and prepuce, finding the corona free from adhesions; slit up the orifice so as to admit a No. 10 English catheter, and tried to dissect the gristly material from the glans. But this last I could not perfectly do, as the tissue extended into the gland substance, and there was no line of demarcation between it and the erectile tissue. After a few weeks it was evident that I had effected no improvement. The surface of the glans got as hard as ever, and the induration along the margin of the prepuce reappeared. But what was most annoying was that, in spite of constant passing of bougies, the meatus speedily contracted again. The passage of a large instrument caused more pain than the patient, though he was a plucky fellow, could bear, and the result was that he was discharged with a No. 4 French rubber bougie, which he passed once or twice daily. He attended some months as an out-patient, and it was only by steady perseverance, in spite of great pain, that he has been able to keep the calibre of the urethra up to the small size it now is.

I need not say that he had all sorts of emollient applications—vaseline, glycerin, iodide of potassium ointment, and so forth—all of them useless. All the treatment I could apply did him little good; in fact, as the hardening since division of the adherent prepuce has extended backwards, it may have done harm. He passes a slightly larger stream by the help of the bougie, but the pain from the bougie is almost as great as the pain used to be from micturition through the pin-hole orifice.

My second case, a strong, healthy lad of eighteen, was also an Infirmary patient. He was admitted in May, 1883, complaining of pain and great difficulty in micturition. The urine came in a very small stream or in drops, and he took about ten minutes in emptying the bladder. This had been going on and gradually getting worse for two years. He had had no venereal disease, and up till his troubles began he had had no difficulty in fully retracting the foreskin.

His condition was almost exactly similar to that of the previous case, except that the prepuce was adherent to the glans closer to the meatus, less than half-way between it and the corona; and at one side of the frenum a deficiency in the adhesion easily admitted a probe, which could be freely moved in the cavity so left. There was the same gristly condition of the frenum, and the same extension of the thickening for a little way down the urethra.

The patient would not submit to etherization, and so no operative procedure was possible. The parts were kept soaking in glycerin, and attempts made to dilate the orifice by bougies. This caused so much pain, however, and the results were so slow and so doubtful, that the patient left when the orifice would admit with difficulty a rubber bougie about the size of an English No. 3. I have seen or heard nothing of the lad since.

What is the nature of this condition? That the stricture of the meatus is of the same nature as the thickened and contracted mucous membranes generally is evident enough. But deeper than this into the nature of the malady it is difficult to go. At first phimosis, and the irritation consequent thereon, suggests itself. But neither patient had phimosis, and the adhesions were least where those in phimosis are usually greatest, namely, over and behind the corona glandis. Repeated attacks of herpes progenitalis might be offered as a cause. But both patients denied having suffered from this, or any other eruptive or ulcerative malady whatever. Both maintained that their complaints came on of their own accord, without any apparent cause.

In fact, to presuppose any inflammatory condition would by no means get rid of the difficulty. Nothing less than a severe scald would beget dense cicatricial tissue so evenly distributed over the whole surface; and no traumatic or inflammatory condition which I have ever seen has left so even a surface behind it. In one of the cases the sclerosis and urethral contraction went on steadily under a medical man's eye without the appearance of any inflammation whatever. Mechanical irritation, long continued, might doubtfully start such a condition, but even then the mischief would not go on increasing after the irritation had certainly been stopped.

I believe that, on the whole, we must regard the condition as a true cirrhosis of mucous membrane, as scleroderma is of the skin. It was clearly not a mere epidermic hypertrophy; the sclerosis deeply involved the fibrous tissues of the glans. The dense tissues were anæmic and transparent, as in scleroderma, and exhibited no line of demarcation from the underlying substance.

The local condition—the pale, glistening, hard, contracted dermis, and the

history, owning no irritative or other exciting cause, tally readily enough with the disease scleroderma; but the situation, on mucous membrane, and the existence of adhesions—not very strong, certainly, but still palpable enough—between orifice of prepuce and glans, are against its being true scleroderma, though not insuperably so. If it is not a scleroderma, I can offer no further suggestion as to what it is.

Whatever be its true pathology, there can be no doubt as to the reality and urgency of its symptoms. The pain during micturition is far more severe than we find in cases of ordinary stricture, and the measure of relief which I have been able to give, after much thought and trouble, has been very small. Removal of the contracted orifice would be so much of an experiment that I should not dare to propose it. And yet, if the spontaneous cure which we occasionally see in cases of pure scleroderma does not take place here, I know of no other means of relieving these patients from their sufferings.—J. GREIG SMITH, *Bristol Med.-Chir. Jour.*, Sept., 1884.

ERYTHRASMA.

THE disease on which v. Bärensprung conferred this appellation, in 1862, had already been described by Burghardt, who attributed it to a well-defined parasite—the *microsporon minutissimum*. It has since been very generally confounded, even in Germany, with other dermatoses. The majority of more recent authors omit all mention of it. The existence of erythrasma as an affection *sui generis*, together with that of its specific micro-organism, has lately been demonstrated anew by M. Balzer (*Ann. de Dermat. et de Syphiligr.*, Vol. 10, p. 681 et seq.). It is my object in the present article both to confirm the accuracy of his statements, and to supplement them with the results of my own observations, extending over a series of years.

Erythrasma makes its appearance in the shape of roundish, neatly circumscribed spots, at first punctiform, but gradually increasing to the size of a dollar or of the palm of the hand, without undergoing central degeneration. These spots, at the outset, are strongly distinguished from the neighboring parts by their color, which is found to differ considerably according to the situation, etc., of the patches. When freshly formed the latter exhibit a more or less vivid erythematous redness, either on their borders only, or over their entire surface. As the eruption becomes older, this appearance gives place to a yellow or brownish coloration, that extends only to the superficial horny layers, and hence is easily removed by scratching. Any slight irritation at such localities suffices to restore a good deal of their former tinge, and accordingly we find on the places of predilection for erythrasma that the patches almost always exhibit a yellowish or brownish redness—a combination of epidermal discoloration with the blush of erythema. These differences in color are easily discernible on any single spot. Individual patches are either circular or rosette-shaped and irregular in outline, being formed in the latter case by the confluence of several adjacent maculæ. Unless very red, they are not usually raised above the level of the surrounding skin, from which the examining finger easily distinguishes them by the roughness of their margins. The borders of erythematous spots, on the other hand, are often slightly elevated, owing partly to hyperæmia and enlargement of the papillary layers, partly to a furfuraceous desquamation of the epidermis, which is most pronounced along the edges. In other respects the skin undergoes but trifling alteration, the papillary layers, in particular, even after the complaint has lasted

for years, presenting merely an erythematous redness, followed by a slight increase of pigment in the basal cells of the rete Malpighi. Exudative formations, such as papulæ or vesicles, are never witnessed. The only subjective symptom to be noted is an itching which for a time may accompany a heightened degree of erythema. In a few instances erythrasma seems to have occasioned an unpleasant liability to intertrigo. Generally, however, no annoying sensations whatever are experienced.

The eruption is usually met with on those parts of the surface which are in mutual contact and exposed to the influences of perspiration, friction, etc., and hence normally in a relaxed and moist condition. Consequently, the scrotum, the inside of the superior femoral region, the cleft of the anus, and the axillæ, are the most frequent—generally, indeed, the only—localities of this parasitical disorder. In these regions it spreads slowly until they are completely covered by the eruption, which often invades surrounding portions of the skin by serpiginous extension. In individual cases erythrasma is often seen in a scattered form even on the trunk and extremities.

The course of the disease is markedly distinguished from that of other dermatomycoses by its chronicity. Few patients are able to say when the complaint began to manifest itself—a fact easily explained by the situation of the spots and the absence of subjective symptoms. As a rule, after the patches have reached a certain development, they remain stationary for months or even years. I have only once seen the eruption in its acute stage.

As to the frequency of the disease it is impossible to speak with certainty. According to Balzer and Besnier, it is “not of very rare occurrence.” From my own observations I am inclined to regard it as quite a common ailment, and on a level in this respect with pityriasis versicolor. If we take due account of its peculiarities as to locality, and the lack of troublesome sensations, this estimate will not appear unwarranted.

Erythrasma is well known—although not as an independent affection—both to the dermatologist and the general practitioner. Many of my colleagues have informed me that they have often noticed “those brown spots on the inside of the thighs,” without paying any special attention to them.

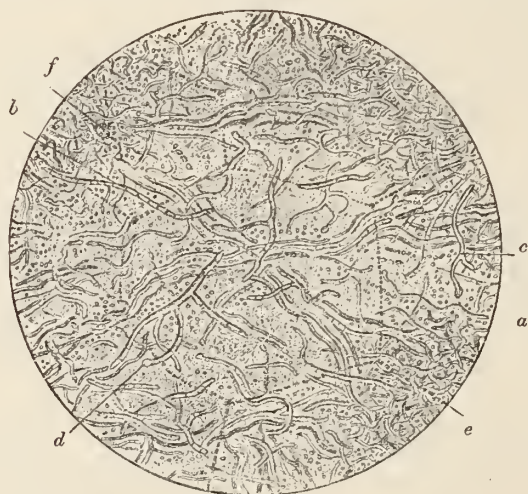
I have never encountered the disease in children. Even Balzer's observations only refer to male adults. Women are seldom affected in this way—so far, only two of my patients were females. The youngest subject was sixteen, the oldest fifty-five.

We have already defined erythrasma as a parasitical disease, caused by the growth of the *microsporon minutissimum*. As in pityriasis versicolor, the brown discoloration of the epidermis is due to this organism, which is found in abundance on every scale. Owing to the superior refrangibility of its elements (in which respect they resemble those of other epidermal vegetations), they are brought clearly into view under the microscope by the addition of an alkali or of acetic acid. The spores are chiefly remarkable for their extraordinary minuteness and delicacy, which might easily cause the conidiæ to be mistaken for cocci, if the characteristic mycelium tubes were not readily made out by a sufficient magnifying power. These mycelium tubes are either simple cylindrical bodies (*a*), of variable dimensions, or their interiors are divided by very evident partitions (*b*). They also ramify dichotomously (*c*), and frequently terminate in small knob-like protuberances (*d*). When occurring in large masses, they are usually grouped very irregularly, so as to form inextricable webs or knots. Bundles of mycelium

tubes are often found radiating in every direction from a single point (*e*). The conidiæ (*f*) are scattered everywhere, and frequently accumulate in great heaps, like those of *microsporon furfur*. The latter parasite bears most resemblance to *microsporon minutissimum*, but its elements are much larger. The accompanying illustration represents a thin scale of epidermis, with mycelium filaments arranged in columns, and aggregations of conidiæ; the whole magnified about 1000 times.

The vegetation is found only in the horny layer of the epidermis. Attempts to cultivate or transfer it, have hitherto been unattended with success.

The diagnosis of erythrasma is comparatively easy, in most cases. The disease is readily differentiated from pigment spots by the desquamation and discoloration which attend it, and by the facility with which the superficially embrowned epidermal layers are removed by scratching. Guided by the same signs, only a very careless observer could mistake smooth pigmented cicatrices for the disorder in question. By far the closest resemblance—as respects the form, color and extent of the eruption, and the condition of the affected surface—is that presented by pityriasis versicolor. Here, not even the almost constant erythematous redness and the remarkable localization of erythrasma, can be regarded as absolutely distinctive, since we often find reddened pityriasis-patches (as in sensitive individuals after washing or rubbing), while, on the other hand, the same disease



is frequently encountered on the favorite localities of erythrasma. In the latter case, to be sure, unmistakable pityriasis-patches will almost always be detected in the body. Notwithstanding this, we sometimes meet with instances in which the microscope alone can decide the question. This instrument is equally convenient and reliable for the purpose, since, in consequence of the abundant growth of their respective parasites in both pityriasis and erythrasma, there is never any difficulty in discovering them, while the elements peculiar to the latter are easily identified by their extreme minuteness. The absence, both of exudative phenomena and of marked alterations in the papillary layer, will prevent us from confounding this disease with either eczema-patches or eczema marginatum. Herpes tonsurans and psoriasis are still less liable to lead astray. Our safest

course, however, is to avoid all possibility of error by withholding a final decision until the *microsporun minutissimum* has been actually seen.

It is scarcely necessary to remark that erythrasma, like pityriasis versicolor, is among the most innocuous of skin diseases. Its prognosis, in comparison with that of other mycoses, is rendered unfavorable only by the possibility that, in the acute stage, it may overspread large surfaces, or by the occurrence of frequent relapses.

Whether erythrasma admits of spontaneous recovery is a point as yet undetermined. Its similarity, however, to pityriasis versicolor, and the fact that it seldom attacks elderly persons, may be taken as evidence that such a termination is not impossible, at least in the more advanced periods of life.

The treatment of this disease is essentially the same as that of pityriasis versicolor and other parasitical affections of its class. We may either remove the infested epidermal layers by friction with soap, iodine tincture, etc., or we may have recourse to remedies which act by destroying the parasite. The latter require a longer time and are less certain in their operation. Extraction of the hairs from the affected regions seems an unnecessary procedure. From my own experience, I can recommend the application of a one-half-per-cent alcoholic solution of corrosive sublimate, and of the unguent. sulphuratum Wilkinsoni. Chrysarobin, in the form of ointment (10 per cent), or in that of a sprinkling-powder (2:100 amylum) has proved equally efficacious, but the resulting irritation must be held in check, and the contiguous surfaces carefully kept apart by layers of wadding.—GUSTAV RIEHL, *Wien. Med. Wochensch.*, Oct. 11, 1884.

PURPURA VARIOLOSA, VARIOLA VERA, AND VARIOLA SINE EXANTHEMATE IN THE SAME FAMILY.

On the 18th of last May, Agnes W., aged twenty-seven years, was attacked, while menstruating, by severe headache, debility, nausea, and very distressing muscular spasms in the face, body, and upper extremities; these nervous phenomena having always occurred, to a greater or less extent, during the catamenia. As there was now some tenderness on pressure in the right ovarian region, while the bodily temperature only rose to 38.5° C., and was normal in the morning, no special importance was attached to her illness, until, on the 21st, a rigor set in, with increased gastric disturbance and headache, and was followed by a temperature of 40.5° C. At the same time a pronounced eruption resembling scarlatina made its appearance, with a good deal of itching, on the face, forearms, and backs of the hands, together with some oedema in the last-named situation and on the forehead. The eruption soon faded, but re-appeared in a short time, and after shifting about for awhile, was succeeded by a nettle-rash of brief duration. These symptoms were accompanied by a high morning and evening temperature, strong beating of the carotids, and a radial pulse of 120; also by very severe sacral pains, and spasms of the lumbar muscles, which allowed the patient no rest in any position, were influenced by opiates, etc., and were only relieved, after continuing three days, by venesection in the affected region. Rigors returned on the 22d and 23d, the high temperature continued, despite the administration of quinine, and the troublesome retching and vomiting steadily increased, with the addition of severe pains in the precordial region. The intellect, however, was unaffected throughout, and, after cessation of the sacral pains, the patient expressed herself as feeling quite comfortable. May 24th, extravasations were noticed in the left conjunctiva bulbi, with swelling of the eyelids; there was also bloody vomiting, hem-

orrhage from the pharynx and genitals, considerable swelling of the labia, hæmaturia, and severe strangury. The mouth and throat were dry; angina and swelling of the tongue made every act of swallowing extremely painful. Towards evening on the 4th, petechial spots appeared upon the abdomen, temperature was unreduced, and death occurred suddenly in the night of the 25th, just after the patient had remarked to her mother how much better she was feeling. An autopsy was to have been made, but was prevented by unforeseen circumstances.

Although at that time, as I ascertained from my brother-practitioners, not a case of small-pox had been observed in the city district where the patient had resided, and not a single indication of this disease had appeared upon her skin, still I could form no other conception of a complaint attended by such strongly-marked evidences of contagion, than that it must be identical with *purpura variolosa*, of which Curschman nsays, in Ziemssen's Cyclopedia, that "it represents the most unfavorable form that small-pox can assume in the initial stage, tending rapidly, as it does, to a fatal termination, before a sign of the characteristic pustule is discoverable." I mentioned my suspicions to the parents, by whom they were not shared, notwithstanding the confirmatory fact that their house abutted directly on the garden of a soldiers' infirmary, where a few cases of small-pox had lately been under treatment. After consulting with my more experienced colleagues—for up to this time I had scarcely had an opportunity of witnessing for myself the course of a small-pox epidemic—I refrained from vaccinating the family—an omission which I had very soon reason to regret.

June 2, Martha W., a sister of the deceased, began to be affected in a similar manner, except that in this instance the rigors were the first marked symptom to make their onset, after two days of general malaise. They were followed by the same initial eruption, headache, gastric disturbance, sacral pains, and high temperature. The symptoms lasted for five days, and then ceased abruptly, the temperature falling at once to normal, although previously almost uninfluenced by quinine and wet-sheet packing. In four days convalescence was fully established without a single pustule having shown itself.

Immediately on the appearance of this case I vaccinated the whole family. Nevertheless, on the evening of June 4th, a third daughter, Clara, aged twenty-five, and previously in perfect health, was seized by the premonitory rigor, preceded by a fainting-spell. In this instance there was no initial eruption, but but after three days of high fever, small red spots broke out on the face, and next day had spread over the entire surface, accompanied by great restlessness and delirium. The subsequent course of the disease was that of genuine variola. Recovery was complete and without excessive debility, in spite of the enormous suppuration.

In all these three cases the contagious disorder manifested itself at the commencement of the menstrual period—a circumstance often noticed in small-pox epidemics. As to the prognostic significance of the introductory symptoms, not not much was to be learned from them. The case of variola vera, however, contributed to prove that in this complaint the number of pustules is inversely proportioned to the intensity of the initial eruption.

The hemorrhagic form (*purpura variolosa*) is usually ushered in, as in our first case, by continuous and very severe sacral pains.

I should not forget to mention that Martha W., the patient who suffered least, had been successfully re-vaccinated three years before, while in the case of her

sisters the operation had never been repeated.—CURT NEUMANN, *Deutsche Med. Wochens.*, Oct. 23, 1884.

ROTHERN-MEASLES. ONE HUNDRED AND TEN CONSECUTIVE CASES.

MARCH 30, 1884, a disorder which at first bore a strong resemblance to scarlatina made its appearance in the Protestant Orphan Asylum, Chicago. The earlier cases being of an exceedingly mild character, no persistent attempt was made towards isolation, but the epidemic was allowed to run its natural course. This it did with increasing severity, until about June 2, when 70 children were in bed, many severely and some fatally ill. The disease now assumed a more malignant form, in some cases still resembling scarlatina, while in others it could not be distinguished from ordinary measles.

One hundred and ten of the one hundred and ninety-six inmates of the asylum suffered from an eruption during the progress of this epidemic; the younger the child the greater its liability, but neither age nor previous exposure brought safety.

Average duration in the first or simple cases was four days; in the severer cases the course of the disease was tedious, and where serious complications existed, of course indefinite. From the circumstances of the case, it was generally impossible to fix the duration of the time of incubation accurately. In two cases, however, it was quite definitely fixed at ten days. Of the *complications*—which were rarely absent in the cases occurring after June 1—perhaps the most frequent among the youngest children was *stomatitis*. It was of all varieties—erythematous, aphthous, ulcerative, and gangrenous, one of the latter being a true noma. This last, of course, was fatal; and in some other cases the termination was hardly more desirable, there being so great a destruction of the soft and bony tissues that the children are left permanently disfigured. The symptoms—profuse pyalism, spongy gums, loose teeth, and horrible fetor—had all the appearance of resulting from mercurial salivation, and yet not a particle of mercury had been administered. Convalescence in all these cases has been exasperatingly slow.

Laryngitis was present after June 1 in about sixty per cent of all the cases. Five of these showed well-marked fibrinous exudates; the remainder manifested more or less aphonia or hoarseness. Two of the cases of fibrinous laryngitis died with disheartening rapidity after the first appearance of hoarseness, and the autopsy in these cases showed so extensive an exudate that I am convinced that tracheotomy would have been of no value. On the other hand, one boy, aged five years, after remaining in an aphonic state for nearly three weeks, during which time he suffered repeatedly from paroxysms of dyspnoea which threatened to cut his life short, finally made a perfect recovery.

Capillary bronchitis, or broncho-pneumonia, was the cause of six out of the nine deaths occurring during this epidemic, but no child without previous lung lesion succumbed to this frequent complication. Other complications were: Diphtheria twice, convulsions once, urticaria once, rheumatism once, dysentery once, and decided diarrhoea in four other cases, although looseness of the bowels was by no means infrequent. Ophthalmia and otitis, either or both, were present in about ten per cent of our cases, generally in connection with some other complication. One poor unfortunate suffered from both of the above, as well as purpura, jaundice, diarrhoea, septic pneumonia, and metastatic abscesses, and yet survives to tell the tale.

Desquamation was not observed in the earlier cases, but in the later ones, to the extent of slight branny exfoliations, it was the rule rather than the exception.

Nephritis, with scanty albuminous urine and more or less ascites, showed itself in two cases, which were, however, promptly relieved by the internal use of infusion of digitalis, assisted by vapor baths.

As to *treatment*, the milder cases were simply confined to bed and given an expectorant mixture, as required for cough. If laryngeal symptoms made their appearance, the use of steam inhalations, by means of a Codman's atomizer, was employed about every two hours.

After the loss of the two cases from fibrinous laryngitis, as mentioned above, the bichloride of mercury treatment was adopted in all cases where a similar accident was feared. *Post hoc*, or *propter hoc*, we lost no more cases in that way, and with our past experience I should certainly try again, under similar circumstances, the hourly use of one-sixteenth of a grain of the bichloride until constitutional disturbance appeared.

The treatment of the severer forms of stomatitis was very unsatisfactory. The removal of the child from the asylum gave better results in obstinate cases than all other measures that could be devised. Where this was impossible, the thorough removal of necrosed tissue by the surgeon's knife, under an anæsthetic, and the subsequent free use of diluted Labarraque's solution and Smith's sulphate of copper mixture, gave us the best results. Generous diet and alcoholics were freely used with advantage in these cases, and Murdock's liquid food served us a good turn in the case of pyæmia previously mentioned.

The *mortality* was a little above eight per cent—a most discouraging result if we accept as true Smith's dictum that rōtheln is never fatal. But of the nine who died three were of syphilitic parents, two were evidently scrofulous, one was already dying of tuberculosis, and the remainder were suffering from chronic bronchitis; so that if we consider it a mixed epidemic of measles and rōtheln, the mortality is certainly rather under than above what might be expected in a public institution.

Finally, this epidemic seems to prove that :

1. Ordinary rōtheln may become so intensified, or complicated with measles, as to be clinically inseparable, one from the other.
2. Previous attacks of measles do not bring exemption from this form of epidemic.
3. The prognosis is graver than with ordinary rōtheln, and less so than in measles under the same circumstances.
4. These facts are theoretically explicable by the hypothesis of a bacterial infection, of increasing virulence, from overcrowding or other favoring causes.—M. P. HATFIELD, *Arch. of Pediatrics*, Oct. 15, 1884.

FATAL CHICKEN-POX.

On the 8th of December, 1883, a child with a fresh eruption of chicken-pox (varicellæ) was admitted to the City Hospital. The disease ran its usual course, and the child was discharged well a fortnight later.

In a neighboring ward was another child—a girl—three months old, who had only entered the hospital in order to be with its mother, who needed treatment for parametritis, the child itself being in perfect health. On December 19, it began to cough, and showed the stethoscopical signs of bronchitis. It vomited a

a little, the stools became somewhat loose, and it lost seven hundred and fifty grams in weight. On December 27, there appeared an eruption in the region of the left scapula, which was much like a *zona*. It was composed of a row of seven vesicles of the size of pin-heads, filled with a clear, watery fluid, and surrounded by a red ring. They followed about the course of the fifth intercostal space from the vertebral column to the posterior axillary line. Just below the lower angle of the scapula was found a group composed of three similar vesicles. All these vesicles increased in size, until ten days later they were a little larger than peas. The contents were then turbid. Several of them had a central depression; others had already dried up so as to form crusts. At the same time there appeared on both sides of the median line at the nape of the neck, several large irregular groups of about twenty similar vesicles. They underwent gradually the common changes of varicellæ. Finally, one vesicle appeared on the left os bregmatis, and one on the processus mastoideus of the same side. This last one occasioned a small diffuse phlegmon, with necrosis of the subcutaneous tissue. After incision and expulsion of the necrotic parts, the wound presented a healthy appearance. No vesicles appeared on other parts of the skin or the mucous membranes. But in the mean time the child lost flesh and was fretful. It vomited a little, but the stools were normal. On the 3d of January it presented the appearance of a child exhausted with cholera infantum. There were no signs of meningitis, no œdema, no signs of any affection of the chest or the abdomen. The bladder contained a very small amount of clear, light-colored, acid urine, loaded with albumin, but with negative test for blood (no microscopical examination). The next day the child died. The temperature had, during the last eight days, mostly ranged from 38° to 39° C. (100.4 to 102.2).

Autopsy.—The tissue below the crusts was normal. The sore on the processus mastoideus reached the periosteum without implicating it. No affection of the cranial bones. No thrombi in the sinuses of the dura-mater. The meninges vascular, but no signs of meningitis. The cerebrum likewise injected, but otherwise normal. No affection of the spinal marrow. In the lungs only hypostasis of the lower lobes. In the large and small intestines, slight swelling of the follicles; no ulcers and very little injection. The mesenteric glands normal. The kidneys of normal size and consistency. The capsule was easily stripped off. The tissue was somewhat cyanotic. The cortical substance grayish, but the contours completely distinct (no microscopical examination). The spleen was not enlarged, and no other organ showed anything abnormal.

The appearance of the eruption was entirely like that of varicellæ, except the distribution. Thomas (Ziemssen's "Handbuch d. spec. Pathol. u. Therap.," II., 2 p. 10) mentions that the eruption may look like *zona*. There had been no case of varioloid in the city for a long period, and nobody was infected from this child.

In exceptional cases, varicella is not the benign disease which is its common characteristic. Temperatures of 105.8° F. and 106.9° F. have been observed by Henoch and Thomas. The skin affection may become gangrenous. A case which recovered has been published by the Danish physician Petit (*Ugiskrift for Læger*, vol. 6, 1842, p. 49). Similar cases have been observed in England by Abercrombie ("Trans. Pathol. Soc.," London, 1880, vol. 31, p. 333), Barlow and Hutchinson (*Lancet*, 1881, II., 751), and Warrington Howard (*Brit. Med. Journal*, 1883, No. 1, 167.) The author has seen varicellæ followed by considerable diffuse phlegmon in two cases which both recovered. Henoch has published four cases of varicellæ complicated with nephritis, one of which, a syphilitic child, died

(*Berliner Klin. Wochenschr.*, 1884, No. 2). In all these the nephritis appeared between the eighth and the fourteenth day. The author himself has treated a child for nephritis appearing a week or two after the eruption of varicella. In this case the urine contained much albumin, blood, and many granular casts. There was no oedema. This child recovered. A similar case has been reported by Dr. G. W. Rachel, of this city, in the *Archives of Pediatrics*, April, 1884.—J. V. WICHMANN, Copenhagen, *Nordiskt Med. Arkiv*, xvi., No. 20.

NERVE STRETCHING FOR ANÆSTHETIC LEPROSY.

THE suggestion first made by Dr. McLeod that nerve stretching might be found useful in the treatment of anæsthetic leprosy, was adopted both in India and Kashmir. In the former country, however, it is now very rarely practised—why, it is difficult to say, since, as far as published cases go, in no other disease has it been attended with such uniform success. I now bring forward 190 cases of the operation, performed in the Kashmir Mission Hospital, upon ninety individuals during a period of three years. Of these ninety lepers, eighty-four improved and recovered sensation, two did not improve, and four died. My own experience was confined to the last thirty-two cases, representing seventy-five nerve stretchings, of which all but one improved.

In most of the lepers who come to us for treatment, anæsthesia is the most prominent, and often the only symptom of the disease, while in the plains the mutilating form is common. Around the anæsthetic parts hyperæsthesia extends, which is commonly a sign of advancing disease. The neurotic affection never, in my experience, extends to the trunk, unless it be merely to a few patches of skin otherwise diseased.

In all but one of the last seventy-five cases there was a definite area affected, corresponding to the distribution of some particular nerve. Of these operations sixty-one were on the sciatic nerve, seven on the ulnar, five on the median, and two on the musculo-spiral. This statement fairly represents the proportion of cases or degree to which different parts were affected. Thus it is most common to find anæsthesia of the feet and anterior aspect of the legs, in many cases the little finger is anæsthetic, and in a few the palm of the hand and the other fingers.

The operation of nerve stretching is of the simplest kind, no dissection being required. Midway between the ischial tuberosity and the trochanter of the femur a vertical incision is made, beginning at the lower edge of the glutæus maximus. The incision should be about 1 to 1½ inches long, and should be made at once through the fascia propria. The forefinger passed under the biceps will, with little practice, at once recognize the sciatic nerve, which should be separated with the finger from its connections, drawn out and stretched. I invariably jerk the leg off the table, using a force of about 25 to 30 lbs., never more than the latter. To the ulnar and median I only apply a force of 4 to 8 lbs. There must always be some risk of injuring the nerves, which in leprosy are weaker than normal. I have twice seen the ulnar broken, once by myself. In neither of these was there any bad result. The operation is almost bloodless, and, with due precautions, would appear to be as nearly absolutely safe as any cutting operation can be.

In none of the last seventy-five operations has there been any inflammation worth recording, nor suppuration. In fifty per cent immediate union of the wound has been obtained. No pain is ever complained of. Within a few days the

patients are always walking about. Normal sensation is recovered by seventy-five per cent of the cases recently operated upon. In most of the remainder sensation was general, though below normal. In a few the feet remained almost entirely anæsthetic. One man alone received no benefit, in consequence of an acute exacerbation of the disease, which almost proved fatal. I have no doubt that though the sphere of this operation is limited, it has yet a great future before it; and that as soon as the certain benefits it bestows become more widely known, it will be as much sought after by the sufferers in India as it is now by the poor lepers of Kashmir.—ARTHUR NEVE, *Edinburgh Med. Journal*, November, 1884.

THE USE OF SALICYLIC ACID IN THE TREATMENT OF LUPUS VULGARIS.

I HAVE for some time employed salicylic acid, in the form of ointment, as a remedy for eczema of the scalp, and impetigo contagiosa occurring in children, with the most satisfactory results, cases that have defied other treatment yielding rapidly to its agency, and I have been induced to make a further trial of it in other skin affections.

By the kindness of Mr. Rigby, surgeon to the Doncaster Infirmary, I was permitted to employ it in a very bad case of lupus exedens, which had been for some time under his care.

The patient, a woman, about twenty-five years of age, had her face terribly disfigured, the ulceration having destroyed one *ala nasi*, the whole of the cheek and eyebrow being also involved. She had been in the hospital before, and had improved under treatment with Donovan's solution and a visit to Harrogate. But on her return, although she was kept under observation and treatment, fresh tubercles developed, and the parts that had cicatrized soon became again involved, and she was re-admitted to the institution. I first tried an ointment of fifteen grains to the ounce of vaseline, which was of no use; I then increased the strength to a drachm, and then to a drachm and a half to the ounce.

The ulcers soon began to heal, no fresh tubercles appeared, the cicatrices became soft and lost their shiny, unhealthy appearance, and the skin of the face is now almost sound. She was taking a mixture containing Donovan's solution and the liquor ferri dialysati. But as this had been administered without apparent benefit before admission, I think it is fair to give the credit to the external remedy. I have not heard of salicylic acid being employed before in the treatment of this particular disorder, and its action seems very satisfactory, especially as it does not appear to cause irritation.—J. G. MARSHALL, *Brit. Med. Journ.*, June 28, 1884.

VACCINIA IN SHE-ASSES.

AT a recent meeting of the Académie de Médecine, M. Blachez read a paper relating to an outbreak of *eruptive fever* in the nursery of the Hôpital des Enfants Assistés. In this institution are kept a number of she-asses for the purpose of suckling the syphilitic children. Each of the animals performs this service for one year—feeding three patients daily—and experience had seemingly demonstrated their non-susceptibility to the specific contagion. Nevertheless, several of them have been attacked by a peculiar disorder, under very interesting circumstances. A syphilitic child, with a sore on its lip, was nursed by a she-ass having a mammary ulcer, which had existed previously to the former affection. This

being the case, ought the animal to be regarded as a source of infection? Whether so or not, certain it is that this same she-ass caused an ulcer on the tongue of a second nursling. About the same time, three other asses, all of whom had been suckling syphilitic children, exhibited mammary ulcers precisely similar their companion's. A sucking donkey was next found to have to have ulcerated gums, together with an affection of the submaxillary glands. Finally, one of the female hospital attendants, who had an abrasion on the hand, and whose business it was to milk the asses, was horrified by seeing the raw spot develop into an ulcer, which was speedily followed by a very painful axillary swelling. These were the facts; and the important question now arose, whether it was possible to explain them on any other supposition than that of syphilitic contagion. Professor Bouley, being called upon for his opinion, replied at once that the animals in question had labored under nothing more or less than "horse-pox." A cow having been subsequently inoculated with virus from one of the suspected pustules, this diagnosis was fully confirmed. All the successive phenomena which had occasioned so much perplexity and alarm were simply the effects of *vaccinie*.—*Le Prog. Médical*.

THE INTERNAL ERUPTION OF VARICELLA.

THAT chicken-pox, like the other febrile cutaneous disorders, may affect the mucous lining of the mouth and throat is a clinically established fact, of which, however, no mention is made by the majority of writers. In most cases this internal eruption is either unnoticed or altogether absent; sometimes, on the other hand, it is quite troublesome and of more importance than the outward symptoms.

According to recent authorities, the interior workings of varicella are not confined to the buccal and pharyngeal membranes; thus, four cases of albuminuria following the disease have been reported in one journal, and a case of nephritis in another. These scattered instances, however, are insufficient to warrant a change in our general estimate of this transient and essentially benign affection.

From a somewhat extensive observation of varicella—especially as met with in a children's dispensary—I am enabled to present the following conclusions:

Varicellous eruptions of the mucous membrane are not of rare occurrence. They are generally found inside the mouth, especially on the dorsum of the tongue and on the palate. Here the vesicles take their rise at an early stage in the disorder, probably sooner than the cutaneous exanthem, but we have never been able to observe them in this situation, owing to their speedy development and rupture, which leaves rounded erosions in their stead. Usually this buccal eruption is of a trivial character, causing but little trouble on mastication. Exceptionally, however, it may set up a severe inflammation, actual stomatitis, which is quickly subdued by chlorate of potassa. In rare cases, the pustular invasion may extend to the mucous membrane of the conjunctiva or of the vulva, but even then it is annoying rather than serious in its manifestations.—J. COMBY, *Le Progrès Médical*, Sept. 27, 1884.

THE OLEATE OF COPPER IN SKIN DISEASES.

THE oleates now used in skin diseases call to mind a home remedy used by my mother years ago. It is to the oleate of copper, more particularly, that I wish to refer. For the cure of eczema and ringworm she prepared a salve after the

following domestic process: About two or three hundred of the old-fashioned copper cents were laid in the bottom of a small copper preserving-kettle, slightly overlapping, so as to leave an open space under each penny. Sweet cream, enough to cover them, was then poured over the pennies, and the whole set in a warm place, not to be disturbed for four weeks. At the end of that time, all things being favorable, through the action of the oxygen of the air and the acids developed, the cream became of a green color throughout. The pennies were then divested of their coating, the cream in the bottom of the kettle carefully collected and thoroughly mixed, and the salve (an ointment of the oleate of copper) was ready for use. It was considered a sure cure for tetter and ringworm, all the country round, and quite a number of remarkable cures might be cited to confirm its merits. In the absence of the old-fashioned penny and the copper kettle, I heartily welcome the oleate of copper, with the positive conviction that mother's remedy has come back to me in more accessible and scientific form.--HOLSBURG, *Therapeutic Gazette*, Oct. 15, 1883.

LABIAL HERPES AND ZONA.

1. THE specificity of labial herpes is as well established as that of zona.

2. In their external manifestations the two diseases differ widely. It is the presence or absence of fever which impresses upon these exanthemata their distinctive aspects. Labial herpes pursues its regular course as one of the *eruptive fevers*; the cutaneous symptoms of zona are much less violent, since it belongs to the class of *simple eruptions*, but it subsequently gives rise to what is denominated by French authors, secondary or suppurative fever.

3. As an exciting cause of labial herpes may be mentioned, first, a sudden check of perspiration. This often happens thirty-six or forty-eight hours before the occurrence of the rigor which foreruns the febrile paroxysm. A second cause is the physiological disturbance induced by parturition. Professor Hardy has remarked the peculiar susceptibility of lying-in women to this complaint, but I believe that the puerperal state not only acts as a predisponent, but is directly responsible for the production of the morbid germ.--LAGOUT, *L'Union Médicale*, July 19, 1884.

BACTERIAL URETHRITIS.

DURING a period of two months, the author, an army surgeon, systematically examined the discharge in every case of infectious urethritis that came under his care, with the result of determining, in three instances, the presence of an organism hitherto undescribed, and concerning which he formulates the following conclusions:

1. Besides those blennorrhagias, by far the most frequent, in which Neisser's well-known gonococcus is always to be found, there are certain other urethra discharges characterized by an abundance of bacterial elements bearing no resemblance to the former.

2. These discharges, like those which contain the gonococcus, may be accompanied by cystitis and epididymitis, and hence require an observance of the same precautions as regards catheterism and exploration of the urethra.

3. It cannot at present be decided whether these newly discovered bacteria originate primarily or secondarily; whether they constitute a type, or merely an accidental product; in other words, whether, in particular cases, the discharge is caused and kept up by their presence alone, or whether they effect their entrance

into the canal, and displace the gonococci, at some time during the progress of the ordinary complaint. Possibly, they act in both these ways.—P. AUBERT, *Lyon Médical*, July 13, 1884.

Items.

AN ABBOT AND HIS ERRING PARISHONER.—*Lyon Médical* quotes the following edifying tale from the *Jour. de Médecine de Bordeaux*. The ecclesiastics, as is well known, have fallen into the bad habit of dabbling in medicine and pharmacy, pretending to know them as well as the Gospels. An abbot named X— was lately the victim of this unfortunate propensity. One of his female parishioners, finding herself in great suffering, consulted a physician in the neighborhood, who regretted to find that she had a well-marked gonorrhoea, and accordingly prescribed copaiba and cubeba in liberal doses. Before taking *these poisons*, the fair one thought it prudent to ask the curate what he thought of them. The latter looked at the prescription and exclaimed, “Balsamics, those are used for the chest. Yours is weak. You can take them.” And, generous to the last, he wrote these words across the prescription, “Furnish at my personal expense.” The story goes on to say that an occasional sly laugh is still called up at the apothecary’s by a perusal of the indorsement on that prescription.

TREATMENT OF SYPHILITIC ONYCHIA.—In the dry form of syphilitic onychia the diseased part should be protected against friction by means of a glove finger or rubber tip, or should be occluded by a dressing of soap plaster. In the inflammatory form, emollients should be used in the earliest stage, then occlusion by bandaging with emplastrum de Vigo. The same means are advised against ulcerous onychia. Prof. Fournier speaks highly of dressings of iodoform; if the ulceration is rebellious, it should be treated with tincture of iodine or nitrate of silver; the acid nitrate of mercury may also be employed, with suitable precautions. Finally, the nail should be removed as soon as possible.—HUMBERT, *L’Union Médicale*, Jan. 3, 1885.

TREATMENT OF LICHEN RUBER BY UNNA’S OINTMENT.—Rockhart has cured in one month a case of *Lichen ruber acuminatus universalis* by means of frictions twice a day over the whole body with the following:

Ung. diachylon.....	500.
Phenic Acid	20.
Sublimate.....	.50 to 1 gr.

—*Monatshefte für Pract. Dermat.*, 1883, No. 3.

TREATMENT OF RINGWORM.—Alder Smith (*Brit. Med. Jour.*, Nov. 1, '84) recommends the use of chrysophanic acid dissolved in chloroform, in the proportion of seven grains to the ounce. He says that it is the most efficient treatment that he has yet tried.



Dr. Taylor's Case of Pigmentary Syphilide.

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ON THE PIGMENTARY SYPHILIDE.

BY

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THE claim originally made by Hardy in 1853, that there is a peculiar pigmentary affection of the skin due to syphilis, is now quite generally accepted in France, England, and America, and within two years its existence has been recognized in Germany.

The chief peculiarities of this affection are the following, which I think are admitted by most observers.

1. That there is a certain chromatogenous affection peculiar to syphilis, which is variously designated, the pigmentary syphilide, the so-called pigmentary syphilide, and syphilitic leucoderma.

2. That the affection appears early or late in the secondary period of syphilis, that it may be the only evidence of the diathesis, or it may co-exist with other manifestations.

3. That its evolution possibly may occur as early as the second or third months of constitutional syphilis, but that it usually appears about the sixth month or towards the close of the first year, and may rather exceptionally be seen to develop during the second and third years. (This is the result of extended observation on my part, and is in accord with the observation of most other observers.)

4. That it occurs most frequently in females, but it is also observed in the male.

5. That it appears most frequently in young persons up to the age of thirty or thirty-five, and that it is rare to see it develop in older persons.

6. That it is seated chiefly upon the lateral portions of the neck, less

frequently on the face (forehead more commonly), and may sometimes be seen on the arms, trunk, and legs.

7. It is composed of irregularly round or oval spots, with either well-marked or ill-defined, even jagged margins of a brown *café au lait* color which does not pale on pressure. The color of the patches may be so faint as to require a strong light, and a certain position for their detection, and even then they might pass for spots of dirty skin. The patches vary in diameter from one-eighth of an inch to one inch, and are never elevated nor scaly. They may be discrete or confluent, in some instances being sparsely scattered, and in others occupying a surface of the extent of one's hand, and presenting very different appearances under the two conditions. In the former, the spots are small and separated by more or less wide intervals of unaltered, or *more or less white skin*.

8. That its duration varies from several months to several years. It rarely disappears under two months. In some cases it is permanent.

9. That it is unattended by any subjective symptoms whatever.

10. That it is uninfluenced in most cases by internal treatment indicated in syphilis, but that it is amenable to appropriate external treatment.

11. That it is to be diagnosticated from chloasma, idiopathic leucoderma, tinea versicolor, from the pigmentations remaining after the disappearance of certain early and late secondary syphilides, from the pigmentations left by eruptions caused by the pediculus capitis and pediculus vestimentorum. Certain leucodermatous spots sometimes left by psoriasis on the parts usually invaded by the pigmentary syphilide might be mistaken for the latter eruption.

These facts thus stated in propositions are generally conceded, the only point now in dispute regarding this interesting affection is, whether it is in reality a leucoderma due to syphilis, or whether it is a true hyper-pigmentation. I have carefully studied many cases of this affection in hospital and in general practice over a period of many years, and I am thoroughly convinced that syphilis causes an abnormal distribution of pigment which we may call, with Neisser, leucoderma syphiliticum, and that it also causes true and distinct hyper-pigmentation to which the name pigmentary syphilide is aptly appropriate. In the following case, carefully observed by me, will be found evidence of the truth of the latter statement.

In the spring of the year 1878, M. S., an unmarried female, a cook, aged 32 years, came under my observation, suffering from syphilis. She had a roscola over the trunk and extremities (my notes say that the neck was normal), active alopecia, mucous patches of pharynx and tongue. The left labium majus was converted into a hard cartilaginous mass, and was superficially ulcerated on its mucous surface. It was on this site that the initial lesion appeared about two months before. She suffered

from rheumatoid pains and nocturnal headache. Though in time antecedent to her attack of syphilis she had been strong and well developed, she was, at the date mentioned, weak and somewhat emaciated. Under appropriate treatment, the lesions disappeared in about two months. During the summer she suffered at times with recurring pains in the bones and with mucous patches. She discontinued treatment in September. During this period she had had a sparse papular eruption on the body. In the winter of this year, 1878, she again came under my observation, suffering severely from nocturnal cephalalgia, which was much aggravated by a too plentiful use of whiskey. At this time she called my attention to numerous spots, varying in color from a light to a quite well-marked brown, seated on the neck and shoulders. These spots, as seen at their most advanced stage, are admirably shown in the chromo-lithographic illustration which heads this article. Though I did not see them until they were well on in the process of evolution, I did have the opportunity of observing some of them appear as very minute spots of the size of the head of a pin, and to gradually grow larger amid the largest ones, as seen in the picture. My interest in the case led me to watch it frequently and critically, and to note all the phases of its progress. Though the patient was actively treated with mercurials with benefit to her cephalalgia, the spots were wholly uninfluenced. The question had been raised early in the year 1878, by my friend, Dr. G. H. Fox, as to whether this affection of the neck was not in reality a leucoderma, and it was ever in my mind. Yet, in spite of the most critical and sedulous study and examination, I was unable to convince myself and several others who saw the case that there was any inter-macular whitening of the skin. It is certain, to my mind, that if the case was considered apart from its syphilitic history, the eruption would have been pronounced to be a *chloasma*. In this connection I must call attention to an admirable chromo-lithographic illustration of the pigmentary syphilide in the second edition of Fournier's admirable "*Leçons sur la Syphilis.*" In this picture the well-marked, clearly defined brown patches are well shown, seated on a back-ground of normal skin. I think, therefore, that we are not warranted by facts in claiming that the pigmentary syphilide is in reality a leucoderma. I have seen many cases in which the pigmentation, like a delicate web of lace, was seated on a well-marked leucodermatous background. In some instances it was evident that there was decided hyper-pigmentation combined with absence of pigment, while in other cases the pigmentation was so slight, and the leucodermatous condition so well-marked, that I felt convinced that there was no deposit of new pigment, but simply an abnormal distribution of the normal quantity of the pigment of the parts. My conclusions are, therefore, first, that syphilis frequently causes hyper-pigmentation of the skin in spots, without any

visible change in the inter-macular skin ; second, that it causes hyper-pigmentation with co-existing leucoderma ; and third, that it also causes an abnormal distribution of the amount of pigment normally present in a given portion of skin in which there is a preponderance of the leucodermatous appearances coincident with the pigment spots.

DERMATOLOGICAL NOTES.¹

BY

W. A. HARDAWAY, M.D.,

St. Louis.

PRiority as to the Use of Traumaticine in Dermatology. In Dr. Alexander's excellent article on the treatment of ringworm, in the last issue of this JOURNAL, I find that he gives Auspitz the credit of the introduction of traumaticine in cutaneous therapeutics. I was long under the impression that we owed this idea to R. W. Taylor, but I have recently discovered that I was mistaken in this. I thought that I dated my knowledge of combining tar, etc., with liq. guttæ perchæ to Taylor's Lecture on Eczema in the series of American Clinical Lectures for 1876. In looking up the subject, however, I observe that it is collodion and not a solution of gutta percha which he advises as a means of making permanent applications to diseased parts. Several years afterward, Sesemann and G. H. Fox, combining chrysarobin with collodion, advocated this pigment in psoriasis.

In adding ol. rusci or ol. cadini to the collodion, the contractile and not the flexible kind must be employed, since when the latter is used, the mixture becomes too oily and does not adhere well, while the addition of one drachm of an oil of tar to an ounce of the contractile collodion converts it into a perfectly flexible preparation. I know of nothing better than this combination of tar with collodion or liq. guttæ perchæ for obstinate eczema about the mouths of children.

But to return to the traumaticine. Any one who will consult the Transaction of the Am. Dermatological Association will see that on Sept. 1, 1880, Dr. J. E. Graham, of Toronto, speaks of his use of a solution of rubber in chloroform in the treatment of eczema of the hands. Whether

¹ I have jotted down these few notes in the hope that the form in which they are presented may commend itself to others. There are many little practical points that are entirely lost because of a natural hesitation as to their fitness for a formal presentation. I hope that the Editors may see their way toward establishing a department of "Notes," thus giving encouragement to the publication of much that otherwise would never come to light.—W. A. H.

he was in the habit of mixing other substances with the gutta percha solution I do not know ; but certain it is that he anticipated Dr. Auspitz in first calling public attention to the merits of traumaticine, although I think all physicians should be under lasting obligations to the eminent German dermatogist for his method of combining chrysarobin with it in the treatment of psoriasis—a most decided therapeutic advance. It seems clear to me, however, that to R. W. Taylor belongs the credit of first directing attention to what may be called the method of fixed applications in cutaneous practice, a manner of using external remedies of great value, and which has been the subject of much ingenious investigation by Pick and especially by Unna, of Hamburg.

Remedies in the Form of Spray. I presume that many dermatologists have used the atomizer in the treatment of skin diseases, but aside from the recommendation of an ethereal solution of iodoform in spray for puritus vulvæ, I think that the good effects of this practice have not been much recognized. My usual habit is to prescribe a solution of definite strength from which the bottle of an ordinary handball apparatus is filled, and the patient is then directed to throw the fine spray on the parts affected. Any substance that is “sprayable,” either in its liquid form, diluted or pure, or in the state of solution, may be thus employed, *e. g.*, carbolic acid, sulphate of zinc, lotions of grindelia robusta, thymol, liq. picis alkalinus, and fluid cosmoline, medicated or not. In the case of the fluid cosmoline, the tube of the atomizer should be large. The spray finds its greatest range of usefulness in diseases affecting large areas and in that class of disorders accompanied by itching and a more or less unbroken cuticle, viz., pruritus, urticaria, papular eczema, and the like. In generalized pruritus, I have gotten good results from spraying on a lotion of the following sort : Carbolic acid, three to four drachms; glycerin, one ounce; and water, a pint. After the bottle of the atomizer has been filled, I sometimes direct the patient to add from five to ten drops of the oil of peppermint. The atomizer bottle should be thoroughly shaken before the bulb is compressed in order to diffuse the peppermint through the mixture, as otherwise it would merely float on top.

In many instances the spray is far superior to mopping on lotions with a sponge or rag, being neater and less troublesome, getting the remedy more evenly and uniformly applied over the surface, and usually giving more speedy relief.

A Good Needle for Electrolisis of the Hair Papilla. For many years I have been casting about for some needle that would more effectually meet the requirements of the operation for the removal of superfluous hair, than the comparatively stiff kind that I had habitually employed. The desideratum was to get a needle that would readily bend yet not break ; a needle, in other words, that would follow the path of the hair follicle,

much as a soft bougie does the urethral canal, and not make a false passage and altogether miss the papilla at the bottom. I am quite sure that the fine, stiff steel needles, even when the temper is drawn, frequently miss the papilla in this way. Within a year Messrs. A. M. Lester & Co., of this city, have furnished me with a needle composed of iridium and platinum which, when used with proper care, will accommodate itself to the follicular canal, and does not readily break. This needle may also be bent by the finger before introduction to conform itself to the supposed direction of a given follicle.

Removal of Small Pigment Deposits by Electrolysis. The electrolytic current has a wide range of cosmetic application in dermatology. Besides its use in hirsuties, I have elsewhere¹ spoken of its merits in warts, moles, small fibromata, milia, and cutaneous horns. It is equally effectual in scattered, very brown or black freckles. In these cases, one should quite gently and superficially prick the pigment deposit here and there with the point of a stiff needle, taking care not to get down to the corium, thus permanently removing the offending pigment without scar.

A CASE OF "PITYRIASIS MACULATA ET CIRCINATA."

BY

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Lately Clinical Assistant to Dr. T. Colcott Fox, at the Westminster and Victoria Hospital for Children, London.

OF the few cases of this disease which I saw at the clinic of Dr. Fox, the following is a good illustration.

Blanche, aged six, first came under the care of Dr. Fox, at the Westminster Hospital, on January 24, 1884. On questioning the mother, she said the child had very little sickness during her life, and had not suffered from any infectious disease. The present illness began about two weeks previous with an eruption which attracted the attention of the mother, who, observing the uncommon appearance of the skin, brought the child to the hospital. The mother stated that three days previous to the eruption the child was frightened, and that she had a slight cold and sore throat.

The eruption seemed to have come out at night more distinctly than at any other time, although it was well marked on each visit to the hospital early in the afternoon.

The mother stated that the eruption came out in successive crops and

¹ "Electricity in the Treatment of Diseases of the Skin." St. Louis Courier of Med., June, 1883.

increased for some days; that it appeared first over the back and shoulders, the axillæ and abdomen, that later the face and scalp became affected, and the back of the hands last of all. The spots were red, moderately irritable, rounded in form, and mostly the size of a split pea, with smaller ones intermingled. The disease in no way affected the health or appetite of the child. On exposure to air, the eruption appeared to fade away, but was readily re-developed by a bath or brisk rubbing with the palm of the hand or coarse towel. When the clothing was removed from the child, it was observed that the face, the scalp, the neck, the trunk, the arms and hands, and the legs down to the knees, were covered with thickly disseminated roseolous, slightly desquamating macules about the size of the little finger-nail. The forehead and palms were free from the eruption.

The mouth was not affected. The eruption over the shoulders, trunk, and back of the neck coalesced in many places; usually the eruption was discrete. On the limbs especially were there to be seen freshly evolved macules, distinely raised, and of a faint rosy or crimson color, about the size of a split pea or larger, round and oval and sometimes irregular in outline. A few of the lesions presented a ringed appearance, due perhaps to the fading color, and subsidence of congestion of the central parts. After the macules had faded away, there remained behind a slight desquamation or roughness, more conspicuous in a bright light, and some pigmentation, which resembled very much certain phases of *tinea versicolor*. The scaling was very constant and characteristic; although more delicate than that of *psoriasis*, it instantly attracted notice. The eruption died away in about a month after the child first came to the hospital. In all the cases which I saw, the disease was a week or more advanced, so that I did not see the earliest appearance of the eruption, but from the histories given by the parents of the children affected, it would seem that the macules evolved first on the limbs or trunk, and that the disease bursts out acutely and profusely and continues for several weeks, the symptoms and characteristic features of the disease diminishing each week. Dr. Fox, in alluding to the situation of the eruption at the commencement, pointed out the fact that it did not always begin on the chest, a fact verified by some of his cases, in contradistinction to Gibert, who says that the disease always commences on the chest and fades in the older parts with its extension elsewhere.

Of the cases seen by me, the chief site of the eruption was the upper part of the trunk and arms. Each macule begins as a rosy, very faintly raised, hyperæmic macule, the size of a pin's head or lentil, and gradually increases, the average size being that of the finger nail, scanty fine adherent scales soon form, and the lesions become more or less ringed. Gradually the bright color fades and the macule resembles roughened

discolored spots, which, when abundant, bear a very close resemblance to tinea versicolor. Each macule generally lasts six or seven weeks, and when it disappears, there remains some roughness and pigmentation.

The disease is liable to be confounded with psoriasis, but the scales are not so thick, prominent, and silvery, nor is the distribution similar to that of psoriasis.

The disease is not parasitic, at least no one has yet discovered its fungus (?).

It must be carefully distinguished from the roseolous syphilide, which frequently comes out in the form of rosy circles, one to two centimetres in diameter, with a yellowish tint, on the thighs and trunks of patients.

Such an eruption may last two, three, or four months, and relapse six, ten, or fifteen months after the initial lesion.

THE ETIOLOGY AND PATHOGENESIS OF DRUG ERUPTIONS.

BY

P. A. MORROW, M.D.

ETIOLGY is commonly considered the weakest, as well as the most difficult chapter of pathology. In the study of the causation of drug eruptions, the problem is much simplified by the elimination of one important element from the list of unknown quantities, viz.: the exciting cause.

The nature of the exciting cause is ordinarily readily apprehended by the physician, or in some cases, suggested by the patient, whose perceptions may have been enlightened by a previous similar experience, or who may be quick to grasp the relation of cause and effect between the ingestion of a drug and the disturbance which oftentimes swiftly follows. In most cases, if there be any doubt as to the causal connection between the drug and the eruption, it is resolved by a comparatively brief expectancy, for, as Bazin has remarked, in no other class of affections is the application of the old adage *sublata causa, tollitur effectus*, so signally appropriate as here. Not only may the *quality* of the exciting cause be appreciated, but, unlike other causes of disease, its exact *quantity* may be definitely determined. It must be admitted, however, that in many drug eruptions the result is entirely independent of conditions of quantity, as it follows indifferently large or small doses.

If the efficient cause of drug eruptions be easily apprehended, the remote or predisposing causes still remain to perplex and baffle the physician; especially is the problem complicated by the existence of that

etiological unknown—idiosyncrasy. Precisely as in the operation of other causes of disease, we find that susceptibility to the irritant action of drugs varies in different individuals and under different conditions. The predisposing causes, such as age, sex, heredity, etc., which exert such a modifying and controlling influence over the production of skin affections in general, play a rôle of minor importance here.

Age and sex seem in no way to dispose the skin to the irritant action of drugs, except from the accident of peculiarities of anatomical structure. As is well known, the texture of the skin of women and children is much less dense and tough than the same organ in man. This greater relative fineness and sensitiveness of the skin renders it more susceptible to take on morbid action, and thus more liable to eruptive disorders from any cause of irritation.

Blond children with fine, delicate, succulent skins are especially liable to eruptive disturbances from the use of drugs, and, besides, the skin of all children is more irritable and prone to disorders of circulation from reflex disturbances. Again, nervous irritability, hysteria, spinal irritation, and other neuroses which, from some unknown peculiarity of organization, are much more common in women than in men, constitutes what may be termed a neuropathic predisposition which markedly modifies the action of drugs.

The comparative influence of heredity as a predisposing cause to drug eruptions is probable from the fact that idiosyncratic intolerance of drugs is rarely an acquired peculiarity. Observations bearing upon this point have not been collected in sufficient number to warrant deductions of a positive character.

Diathetic predispositions exert a marked influence in determining drug eruptions. This has been especially observed in the case of local irritants, the eruption becoming generalized and persisting long after the exciting cause has ceased to act. In these cases it is probable that the drug would be without pathogenetic influence were it not for the predisposition to eruptive disorder constituted by the peculiar diathesis, the existence of which is a necessary condition of its operation. Eczematous subjects are particularly prone to drug eruptions.

The most powerful predisposing cause of the determination of the irritant effects of drugs towards the cutaneous surface is the physiological predisposition known as idiosyncrasy. While the term is intrinsically meaningless, yet it is convenient to express that abnormal susceptibility to external impressions which is manifest in certain individuals, a condition which has been regarded as inexplicable as it is mysterious. The existence of idiosyncrasy as an etiological factor has been accepted as an ultimate fact, unknown and unknowable.

While we may not be able to draw aside the veil which shrouds

this "mystery of individuality," yet it should not be allowed to obstruct what light may be thrown upon the explanation of those phenomena for which idiosyncrasy stands as the *fons et origo* from our knowledge of the physiological properties of the tissues and their mode of reaction to external impressions.

Idiosyncrasy has been termed the bugbear of therapeutics; but this factor, as influencing the action of drugs, is no more mysterious than the predisposition which is manifest in relation to the action of other exciting causes of disease, and which determines the morbid effect to this or that particular organ. To take a familiar example, of a certain number of individuals exposed to the action of cold, as in wetting the feet, the morbid impression may be reflected upon the respiratory mucous membrane, producing in one case sore throat, in another bronchitis, in another pneumonia or an attack of asthma; or it may be reflected upon different tissues altogether, producing in one case neuralgia, in another rheumatism, in another congestion of the kidneys, etc.—the same morbid influence determining disease of a particular organ, varied in form and intensity, or even different diseases. In the explanation of the mode of production of these phenomena, we do not take refuge behind idiosyncrasy as a cloak for our ignorance, but we assume the existence of a textural predisposition in the affected tissues, constituted, it may be, by inherent weakness or antecedent disorder, which renders them *partes minoris resistentiæ*.

So, also, the determination of the irritant action of a drug towards the cutaneous tissue implies either the existence of structural peculiarities of the skin, enfeebling its capacity of resistance, or a heightened susceptibility of the nerves which regulate the circulatory and nutritive processes of this organ. It is by no means clear whether this morbid aptitude of the skin to irritant action is due to anatomical or histological alterations in the cutaneous tissues, too subtle to be seen or demonstrated, or to an abnormality of the nerve-element which may be expressed as "erethism" or "irritability."

Approaching the study of this etiological factor from another direction—Begin defines idiosyncrasy as "the predominance of an organ, a viscus, or a system of organs." Experimental investigation has demonstrated that "the law which governs the susceptibility to the action of drugs is that the more highly specialized any system is, the more readily it is affected by a medicinal agent." We find in persons most susceptible to anomalous eruptions that the nervous element or temperament predominates.

And, moreover, since the same individual may exhibit two or more idiosyncrasies, this peculiarity of development may be manifest in relation to both the skin and nervous system. Conjoined with this highly wrought

nervous organization, the skin itself may be more highly differentiated by fineness and delicacy of structure and endowed with a more exquisite sensibility. We have seen that women and children who, as a rule, possess thin, delicate skin, are peculiarly prone to these eruptive disturbances. Again, as an evidence of the fact that pathological predispositions are analogous to physiological predispositions, we find that neuropathic individuals, the nervous, hysterical, patients debilitated or cachectic, or who suffer from any of the protean forms of neurasthenia, are precisely the persons most liable to manifest idiosyncratic intolerance of drugs. A predisposition to drug eruptions may inhere in the skin from "native debility," or it may be created by any disorder which weakens the tissues, just as a non-specific inflammation of any organ disposes it to more readily take on subsequent inflammation. It has been observed that one attack of a drug eruption seems to confirm and intensify the susceptibility to subsequent attacks.

PATHOGENESIS.—There is a difference of opinion among writers as to whether these eruptions should be classed among the physiological or toxieological effects of the drugs producing them. The term pathogenesis, implying a pathological process, is employed with a clear recognition of the close lines which unite the physiological and the pathological. As pathological states are but modifications of the healthy state, so the toxic effects of a drug differ in degree, but not in essential nature from its physiological effects; there is no definite limit where the one ends and where the other begins. A large proportion of drug eruptions are an expression of the drug's physiological action, while others are merely incidental thereto. These last depend upon conditions of the organism, obscure, no doubt, and imperfectly understood, but which the element of accident does not place beyond the pale of the physiological.

Excluding from consideration the class of agents known as escharotics, we will first briefly refer to the changes in the skin caused by the external application of certain drugs. The links in the relation between cause and effect are here distinctly traceable, and the mechanism of their action is explicable on purely physical and chemical grounds. The intensity and severity of the congestive and inflammatory disturbance produced depend upon the nature of the agent employed, the duration of its contact, and other circumstances, such as the sensibility of the skin and the mode of reaction of the individual. Certain effects, to be considered later, are the result of the absorption of the drug through the skin, and are analogous to those which follow its internal administration. A clinical distinction may be made between effects which invariably follow contact with certain drugs and those which are occasional and irregular in their manifestation.

The first class of effects is determined rather by the nature of the drug

than by any peculiarity of organization or mode of reaction of the skin. They are so constant and characteristic that we may recognize the nature of the agent employed by the form of its lesion. The blebs of cantharides, the pustules of antimony and croton oil are characterized each by a special evolution, and are as typical in their forms as are the pustules of variola. We cannot explain why the irritating influence of different drugs are exerted upon different constituent elements of the skin, any more than we can explain why the pathological changes met with in measles should be grouped around the blood-vessels and glands, while in scarlatina the pathological process affects the tissue proper of the derma, as well as the cells of the epidermis.

In general, it may be said that the effect of a cutaneous irritant is limited to the vascular area supplied by the affected nerves. The irritating effect may sometimes pass beyond this limit and invade adjacent portions of the skin, or it may be diffused over the entire surface. This may be explained by the existence of sympathetic lines which unite different portions of the same apparatus, or upon the assumption that it is due to the absorption of the drug and an expression of its constitutional action.

The second class of effects is far from being constant. Their production seems to depend less upon the intimate nature of the exciting cause than upon a specific predisposition of the cutaneous tissues to disordered action, which may be expressed by the term *morbid aptitude*.

As in the case of anomalous eruptions from the internal use of medicines, the eruptive form is determined rather by the individual than by the drug. Thus we recognize in "tar acne" the specific irritating effect of tar upon the cutaneous tissue; but in one individual the use of tar may produce a simple dermatitis, in another erysipelas, in another a pustular or a furuncular inflammation, while, in the large majority of individuals, it will cause no eruptive disturbance whatever, the difference of the effect depending upon the reaction of the skin in different individuals.

This variation in susceptibility to irritant influences of the skin of different persons may depend upon physiological conditions, such as a greater fineness or delicacy of texture, or upon a peculiar excitability or irritability of the sensory nerves which disposes them to take offence at the slightest provocation. We find that this vulnerability of the skin which renders it abnormally incapable of resisting disturbing influences is manifest in relation to poison ivy, vegetable parasites, the exciting causes of eczema, and, in fact, all external irritants.

The cutaneous changes caused by the external application of drugs admit of a simple explanation. The drug acts just as caloric or mechanical irritants do, upon the nerve element alone, the resulting changes be-

ing phenomena of irritation. The irritation of the peripheral extremities of the sensory nerves causes a paralysis of the vaso-motors of the vascular area affected, which results in dilatation of the blood-vessels, and which may go on to typical inflammation of the skin with exudation. In one case the specific character of the irritant determines the eruptive form; in the other the response to the stimulus is materially modified by the physiological properties of the tissues affected.

We come now to a consideration of that class of eruptions which result from the introduction of drugs into the system by way of absorption. Instead of a direct irritant influence upon the skin, the drug stimulates all the blood-containing organs with which it comes in contact. It affects the centres of sensibility as well as the peripheral nerves, and the pathogenetic mode is much more mysterious and difficult of comprehension.

The eruptive disturbances which follow the internal use of drugs may be divided into two classes :

1st. *Common, specific eruptions* which are more or less characteristic in their anatomical form, mode of development, and locality affected, and which are associated with the other physiological effects of the drug.

2d. *Incidental, anomalous eruptions* without distinctive form or character, which manifest dissimilar eruptive elements, and which may be associated with the physiological effects of the drug, or merely incidental thereto.

In this connection it may be well to recall some of the more characteristic features of drug eruptions. In the first place, it must be borne in mind that the same eruptive form may be produced by different drugs, and that the same drug may produce a variety of eruptive forms. It is not possible, therefore, to establish a distinction between these classes based exclusively upon the anatomical form of the lesions, since one drug may exhibit characteristics of both classes. Thus the type of the quinine exanthem is erythematous, but exceptionally, it may be eczematous or purpuric. Iodide of potassium ordinarily produces a papular or pustular eruption, but instead, or indeed coincident with this specific form, there may be an anomalous eruption of dissimilar forms. In cases reported by Pellizzari, for example, side by side with an acneiform eruption there were bullæ and large subcutaneous nodules.

Again a drug eruption, the type of which is erythematous, may, under special conditions, such as the prolonged continuance of the exciting cause, be developed into a papular, vesicular or pustular eruption.

In other cases, there is no mutation of forms, the indefinitely prolonged use of the drug will be unattended with any essential change in the character of the eruptive element. If it commence as a papular or a pustular eruption, it will continue as such, independent of the dose or duration of the drug. It is to be noted, however, that when the lesions

are in process of involution, if the drug be renewed, it will cause a *poussée subintrante*, and we may have different forms side by side, some in active evolution, others representing the acme or completion of the morbid process. while others are on the point of disappearance.

We perceive, then, that in endeavoring to appreciate the mode of production of these eruptions, it is impossible to adhere closely to the distinction between specific and anomalous eruptions, since there is nothing absolutely constant, nothing definite, nothing fixed in their respective forms, they are as varied in their manifestations as are the physiological peculiarities of the individuals producing them. It is to be observed, however, that difference in effect does not necessarily imply difference in mode of impression. We think that most writers err in attempting to differentiate pathogenetic modes upon the basis of difference in anatomical form of the lesions. Anatomical form is as misleading in pathogeny as it has proven defective as a basis of classification. Notwithstanding the diverse character of drug eruptions as indicated above, we have seen that they all possess one distinctive, generic feature, which stamps them with the seal of a common causality of origin—they always promptly disappear on the withdrawal of the exciting cause. The more or less rapid removal of the cause is of course subordinate to conditions of elimination; the celerity of this process varying in the case of different drugs. The rapidity of the disappearance will also vary according to the nature of the lesions; obviously the slight cutaneous disturbance expressed by a simple erythema would not require the same time for its involution as the more profound tissue changes, represented by an inflammatory nodule, or an ecthymatous ulcer. Again, it is to be borne in mind that diathetic predispositions awakened into activity by an irritant drug may impress the character of chronicity upon the resulting skin lesions—the inflammatory fluxion to the surface persisting long after the cause which determined it has ceased to act.

(To be continued.)

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

152D REGULAR MEETING, FEBRUARY 24TH, 1885.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. ROBINSON presented a case of

ACNE.

The patient, a single man, 25 years of age. Has had the present eruption

for about four years. The whole area of the back, extending from the neck down to the sacrum, is covered with acne, there being many indurated lumps, as well as large pustules. Scattered between the acne papules are large cicatrices produced by the breaking down of former papules and pustules. There is a slight amount of eruption on the face and chest.

Dr. Robinson said that he showed the case on account of the extent of the eruption on the back and the great loss of tissue.

Dr. SHERWELL showed a case of

ICHTHYOSIS.

Julia W., 9 years old. German parentage. The patient's mother noticed the eruption when the child was two months old and it has remained ever since. Now the whole body is covered with a characteristic eruption of ichthyosis; the face, hands, feet, and upper and lower extremities are affected, the lesion also extends beyond the labial folds on to the mucous membrane at the entrance of vagina. The axillæ appear to be the only portions of the body free from eruption. There is also a great amount of ectropion.

Dr. MORROW thought that there was a greater generalization of the disease in this case than is usually met with. He had never seen the lesion developed on the palms and soles to such an extent. He also thought that the development of the disease as early as the second month was of very rare occurrence. Numerous inquiries which had been made relative to the time when the ichthyotic condition was first observed would seem to indicate that it is rarely noticeably present at birth or within the first six months. There is a superstition among the common people that the mother's milk has a preservative influence against the development of the disease. He would explain this apparent exemption during the earlier months of infantile life by the fact that in consequence of the skin being more soft and tender, and it being subjected to frequent ablutions, the epidermal scales were not allowed to accumulate.

Dr. TAYLOR asked Dr. Morrow if the frequent ablutions prevented the development of the disease.

Dr. MORROW said that they did prevent the accumulation of the scales which were the evidences of the disease, although the development was not retarded. In proof of this assertion he cited the fact that patients suffering from ichthyosis were much better in summer; because of the increased perspiration and also the more frequent cleansing of the affected surface.

Dr. TAYLOR wished to know, if there were a tendency to an eruption of ichthyosis, if washing would not be apt to hasten the appearance of the lesion.

Dr. MORROW did not consider ichthyosis an eruption, but a congenital malformation of the skin.

Dr. SHERWELL said that he merely presented the case because the lesion covered such an extensive area.

Dr. ROBINSON said that he did not regard ichthyosis as an eruption in any sense of the word, but an abnormal growth of the corneous layer of the skin, so that washing would prove beneficial because it would remove the scales that were constantly being formed. He always had found the sweat glands well developed and he attributed the dryness to the excessive formation of scales which prevented sweating. He thought that there would be as great dryness in a severe case of squamous eczema. He had, however, found the sebaceous glands undeveloped.

Dr. BRONSON showed a case of

PAPULO-ERYTHEMATOUS ERUPTION WITH ECTHYMATOUS ULCERATION DUE TO TROPHONEUROSIS

which was presented for diagnosis at the last meeting. The patient, Rosa S., seven years old, with a peculiar papular eruption, situated on the upper and lower extremities.

Dr. Bronson showed the case that the improvement in the child's condition might be seen. In most instances the papules had disappeared, leaving only efflorescences. In some places, as on the right elbow, there were ecthymatous masses, and on the legs there were a few patches covered with a scab, which, when removed, revealed a granular surface beneath. The treatment had been small doses of Fowler's solution.

NARRATION OF CASES.

DR. JACKSON said that he had lately seen a case of

SUPERFICIAL EPITHELIOMA OF THE UPPER LIP,

occurring in a patient sixty years old. He mentioned the case because of the rarity with which the disease occurs in that situation.

DR. SHERWELL then made a few remarks on the use of

PURE BENZOLE IN THE TREATMENT OF EPITHELIOMA.

He now had a patient under treatment, suffering from cancroïdal ulceration (rodent ulcer) around the eye, to which he was applying pure benzole. The object was to mummify the tissues, as it were. The application did not cause pain, but on the contrary, acted as an anæsthetic destroying the sensibility of the parts and blanching the cells. After a short time a scab is formed which should be removed and more benzole applied. He was inclined to think that it could be used in cancer occurring at the os uteri. He had used the drug at the suggestion of Dr. Mathewson, of Brooklyn.

DR. BRONSON asked if the preparation could not be used in Paget's disease of the nipple.

DR. TAYLOR then gave the history of a case of

FOLLICULAR CHANCRE OF THE PENIS,

two cases of which he had lately seen. He narrated the case because very little had been written upon the subject of follicular chancre.

On January 5, 1885, a young man, twenty-six years of age, came to me, who said that three weeks before he had connection with a mulatto in Texas. When I saw him he presented behind the sulcus on the dorsum of the penis a little red swelling about the size of a milium, in the centre of which was a depression like the orifice of a sebaceous follicle. There was no lesion of continuity present. At that time the swelling did not appear to amount to much, although the patient was anxious, as he had his doubts in regard to the condition of the woman. This small spot increased until the lump was the size of half a pea, and at the same time the inguinal glands enlarged, as did the dorsal and lateral lymphatics. The depression in the centre of the spot also increased in size and ulcerated. About February 5, the morbid mass, together with the lymphatics, greatly resembled a miniature flute, with the flaring end at the surface. The chancre was then about the size of the end of my little finger, and the lymphatics as large as a goose quill. There was so much cedema present that I gave the patient the protoiodide of mercury internally, and externally mercurial inunctions, with the effect of causing the mass to melt away.

About the same time I saw an exactly similar case.

I believe these to be cases of follicular initial lesion, analogous to the follicular chancroid.

It seems to me that in these cases the syphilitic secretion must have insinuated itself into the follicle, as there was no abrasion, and I watched the case carefully for two weeks. After the syphilitic matter had been introduced into the follicle, it gradually increased, the hardening process extending at the same time, the walls of the depressed portion were forced open, and the condition described was the result.

DR. MORROW asked if the diagnosis was based upon the fact that the lymphangitis disappeared under the use of mercury.

DR. TAYLOR said that he based his diagnosis on the fact that the sore made its appearance twenty-one days after intercourse, and that infiltration and induration took place in the follicle. What else could it be?

DR. FOX said, assuming that the sore was non-specific, would it not disappear under the use of mercury?

DR. TAYLOR replied that the disappearance of the induration under the use of mercury was to him confirmatory of the fact that the lesion was a chancre, and that the swelling produced by a chancroid could not be removed by mercury.

DR. FOX then spoke of his experience in the use of

COCAINE IN EPITHELIOMA AND HERPES.

He had applied Marsden's arsenical paste to portions of the epithelioma in the patient presented at the last meeting, each time putting it on patches of more than an inch square. He had also used a four-per-cent solution of cocaine with good results, dropping it on the surface, drop by drop, for about three-quarters of an hour until the parts were anæsthetized, when the surface could be scraped without causing pain. He also referred to a case of lupus of the lip in a woman, to which he applied six minims of an eight-per-cent solution of cocaine with the effect of producing anæsthesia. In operating about the nose and upper lip, he passed one of the finest hypodermic needles under the lip above the canine eminence as far as the nerve, and injected an eight-per-cent solution of the drug, and after the lapse of about five minutes, there was complete anæsthesia. No abscess was formed afterward.

DR. MORROW said that he applied a four-per-cent solution of cocaine to a rodent ulcer, involving the nose, upper lip, and cheek. The caustic used was a saturated solution of chloride of zinc, which, when applied without previously using cocaine had caused intense pain, but when the latter was used before cauterizing, he found that the sensibility of the mucous membrane of the nose was entirely destroyed, although at the point where the disease encroached upon the upper lip, the cutaneous sensibility was not materially lessened.

DR. SHERWELL had used a four-per-cent Merck's solution in anal fissure, applying as much as sixty minims. He first introduced twenty minims about two inches above the opening, plugged the part, and waited eight minutes, then introduced twenty minims, waited ten minutes, and finally twenty minims, waiting fifteen minutes. He then introduced the speculum and cut the fissure without causing any pain until collodion was applied, when sensibility returned to a certain degree.

In removing laryngeal tumors, he had not found that the drug produced anæsthesia. He had only met with success when he wished to anæsthetize the parts for the purpose of viewing the posterior nares and back of the throat.

DR. TAYLOR showed a

URETHRAL SYRINGE,

devised by Ultzmann, of Vienna, and used for deep urethral injections. It consists of an ordinary syringe of solid silver, with a graduated hypodermic syringe attached to the upper end. By means of the graduated portion the exact amount to be introduced into the canal can be determined with precision. It is of great service in making injections for the purpose of relieving the aching of the perinæum caused by masturbation or stricture.

Reviews.

A MANUAL OF DERMATOLOGY. By DR. A. R. ROBINSON, M.B., L.R.C.P.S. Edin., Professor of Dermatology at the New York Polyclinic, etc., etc., etc. Pp. 647. New York: Bermingham & Co., 1884.

As would have been predicted by any one familiar with the professional career of Dr. Robinson, he has produced an exceptionally meritorious work in the one before us. Although this work is not *the* book which the author has long cherished an ambition to write, and although it was written under contract and also under great pressure by reason of sickness and professional occupation, the aid of Dr. Gottheil being found necessary to complete it, the result is on the whole so satisfactory that it furnishes abundant reason for believing that the much larger, more pretentious, and more original work of which it is the forerunner, will prove to be one of the best treatises on dermatology in the English language. It is to be hoped, however, that the promised work will not be very much larger, as this modest production is altogether too heavy for comfortable reading.

Too severe criticism of the larger part of the work is deprecated by the frank admission that the description of a number of the diseases is more or less copied from standard works on the subject, and however strongly the reader may feel disposed to express the opinion that a man who has the courage to undertake to write a book should scorn to copy, yet, as the author's object was to present a concise account of our present knowledge of dermatology, it will suffice to say that the copying and compiling have been done with good judgment, and that Drs. Robinson and Gottheil have not only accomplished the object which the former had in view, but that the product of their joint labors is also a decidedly original and instructive work, the latter not only for the student and practitioner, but also for the better informed specialist, whose mind is supposed to be crammed with the learning contained in the numerous monographs and treatises which have recently appeared.

The opening chapter on the anatomy of the integument is concise and yet comprehensive, and is especially interesting on account of the original views it presents on the obscure subject of terminations of the nerves in the skin. The Pacinian corpuscles are described as being composed of a great number of capsules, concentrically arranged around a central elongated clear mass, and the intimate structure of the capsules is minutely described. It is unfortunate that, in the text, both the tactile and the Pacinian bodies are spoken of only as "corpuscles," and that the foot-note on page 20 may, by reason of the omission of a (*) in the text, be read as referring to either of these structures. The plate given to show the formation of the Pacinian corpuscle does not exhibit the intimate structure of the capsules, and some of the explanatory letters attached to Fig. 15 are not alluded to in the context, which is somewhat puzzling to the reader, who is left to wonder why the figure was introduced. The view advanced so positively by Unna that the ultimate nerve-filaments end in pairs in the prickly-cells of the rete in or near the nuclei, is not supported by Dr. Robinson, who says, very justly as it seems, that, if the cells of the rete afterwards become corneous cells, this mode of termination can hardly be possible.

The chapter on physiology is extremely condensed, only four pages being devoted to this important subject. Although the conclusions advanced seem on the whole to be in keeping with those held by the majority of recent investigators of this subject, yet exceptions might be taken to some, notably to the statement that "probably all the sweat or watery liquid which reaches the free surface comes from the sweat-glands proper." This opinion may be regarded as misleading, in view of the weighty arguments which have recently been advanced to show the functional participation of various structures in the formation of sweat.

The classification adopted is that of Hebra, with some modifications. A word of commendation is bestowed upon the system of Auspitz, but our author has no respect for the nomenclature of the American Dermatological Association, seemingly because "it was decided by balloting."

The sections devoted to etiology and treatment throughout the book are as a rule extremely satisfactory. The balance is judiciously held between the constitutional and the local origin of the diseases and local and general treatment, undue prominence being given to neither. In discussing the treatment of eczema, the chronic and the acute forms are considered under separate headings, a distinction which will at once strike the eye of the general practitioner seeking aid from the book, and impress this very important matter indelibly upon his mind.

Under lichen planus, we are told that "arsenic should not be given in this disease, as it frequently aggravates the eruption," advice judicious enough on the whole, but somewhat too exclusive, as some chronic cases have undoubtedly been benefited by this agent, and it is justifiable to make a trial with it when everything else has failed.

A separate chapter is devoted to dermatitis, under which a concise but careful description is given of the various drug eruptions.

The most striking feature of the book is, however, the prominence given to the pathological histology of the different diseases. About sixty of the large number of woodcuts are evidently original drawings from specimens made by the author, and although some of them will at once be recognized by readers of the numerous excellent monographs which the author has published during the past ten years, the majority are new, at least to the writer. As a rule, they illustrate in an extremely lucid manner the views advanced in the text, and force upon the reader the conviction that what the author says upon the subject is absolutely true. After looking at Fig. 45, *e. g.*, it is difficult to understand how any one can doubt that hyperplasia of the rete Malpighii is the essential alteration in psoriasis. On the subject of the pathology of this disease, the author refrains from controversy, but presents his views as a statement of facts, which seems justifiable in view of the fact that they have been accepted as correct by so many competent observers, notably Jamieson and Thin.

The distinction between lichen planus and lichen ruber is forcibly brought out, and the descriptions of the two diseases are separated by two hundred pages of the book, which renders it more easy for the student to prevent the resemblance of the names from leading him to confound the two affections. Lichen planus is shown to be due to an inflammatory process in the papillæ and upper part of the corium, and lichen ruber a hyperplasia of the epidermis, "a paratypical keratosis." It would, perhaps, not have been superfluous if the author had told his readers what a paratypical keratosis is, or had told them that they will probably never see a case of lichen ruber unless they go to Vienna, as he does when speaking of prurigo.

Sycosis is described as a distinct disease, and a minute account of its symptoms, pathology, and treatment is given. We are told that the eruption in the majority of cases is preceded by a chronic eczema, and that in the latter disease the papules or pustules are not, as a rule, perforated by hairs, whereas in uncomplicated sycosis this is always the case. The distinction between the two affections would therefore seem to be somewhat difficult in practice without the aid of the microscope, and it may seem to some hardly worth making, especially in view of the circumstance that their treatment does not differ materially.

Pompholyx is placed among the non-contagious inflammatory affections, the author believing it to be a neurosis, closely allied to herpes. The descriptions of the disease given by Hutchinson and Fox are reproduced, and then the history of a case which came under the author's care is detailed. A plate showing the formation of the vesicles without implication of the sweat-glands adds much to the clearness of the description of the pathology of the affection.

Under the term scrofuloderma, granulation tumors of the lymphatic glands and their sequelæ are described.

The contagiousness of molluscum is denied, and yet the deceptive adjective is retained in the name. Dr. Robinson has never found the tumors to be connected with the sebaceous glands, but has always noticed that they developed from the rete cells in the external sheath of the hair.

Under *tinea trichophytina*, a woodcut is given which shows the fungus to be seated not only in the hair and its root-sheaths, but also in the corium, an observation which, like many others in the book, is original with the author.

The style in which the work is written is not pleasing by its ease and fluency, but is, in the main, rather jerky and stiff, as if written in a hurry and without much pleasure on the part of the writer. There are also altogether too many mistakes, showing careless proof-reading, and the author in one place speaks of himself as "I," and in the succeeding sentence as "we." But these are, after all, trivial defects which detract but little from the value of the work, and will doubtless be corrected in the new edition which will ere long be issued, if the book obtains the large number of readers to which its merits entitle it.

Selections.

LUPUS OF THE PUDENDUM.

THIS remarkable disease affects women chiefly during the child-bearing period of life. I have seen it in a child, but at that age it is extremely rare, and I may interpolate the remark that it does not occur in males, or, at least, is very rare in that sex. The disease is generally said to be very uncommon even in women, but that is not my opinion; in this hospital we are seldom without several cases during the session.

It is curious that a case of *lupus minimus*—one small in measurement—has never been observed to grow into a case of *lupus maximus*—one of great measurement, either of hypertrophy or destruction—or *vice versa*. Yet such growth must take place.

A case of *lupus minimus* may very naturally be classed, on superficial examination, with urethral caruncle, or eczema of the vestibule, or pruritus pudendi. A case of *lupus maximus* may be taken for one of tertiary syphilis, or of elephantiasis, or of cancer. I have no doubt that the alleged rarity of the disease is to be accounted for by such mistakes.

Lupus of the female genital organs is best known as a disease of the pudendum and neighboring parts; and these are really far most frequently its seat, but it may spread over the adjacent parts of the thighs and the hips. It may attack the vagina and the urethra and rectum; it may attack the cervix and body of the uterus. I do not know of its attacking the tubes.

It is interesting to notice that the face and the pudendum in women are the favorite seats of this kind of disease; and any one familiar with the appearances in the face recognizes some degree of similarity in cases of the disease in the pudendum. There are, so far as my observation goes, no tubercles to be seen in the pudendal disease. Why this should be so I cannot say.

The cases have a general outward similarity which is readily recognizable; and there is a uniformity of structure as revealed by the microscope—no new or specific elements being found, but the presence of young or growing tissue with many leucocytes, these often grouped around the vessels. Dr. Thin has told me that the disease is histologically unlike ordinary lupus, the morbid structure being diffused in the affected parts, not occurring in nodules or tubercles. Whilst in ordinary lupus the cells undergo a series of retrogressive changes, in the disease of the pudendum the cells are found either as simple white blood-cells or as ordinary connective cells in various stages of development. In ordinary lupus the distinctive cells are associated essentially with destruction of fibrous tissue; in the pudendal disease they are associated with formation of fibrous tissue. I have failed to trace, clinically, any connection of the disease with scrofula. No doubt in some cases it is a syphilitic disease, but we have only very rarely met with evidence of the fact. The women affected are often of a fine, healthy, even blooming appearance. The disease has a peculiar history and such extraordinary changes or transformations as to separate it from every other.

This lupus is characterized by ulceration, *lupus ulcerosus*; by destructive ulceration, *lupus exedens*; by hypertrophy, *lupus hypertrophicus*. There may be no hypertrophy in one case, and in another there may be no ulceration, or such destruction as is implied by *exedens*. I have never seen great hypertrophy without some ulceration, but often without marked destruction of parts; ulceration and ulcerative destruction without hypertrophy are not rare. Besides, you have discoloration often, and often inflammation of the affected parts, and of the neighboring organs—the urethra, the bladder, the vagina, and the rectum. We had a case in which there was inflammation and stricture of each of the three passages.

The disease gets its name *lupus* from the ulcerative destruction which it frequently causes. The ulcers, whether exedent or not, secrete pus copiously, sometimes laudable pus, sometimes thin and watery. They may affect hypertrophied parts and have no destructive quality. They may cover a great area, the extent not being discovered until the parts are unfolded. They may burrow and be like abscesses, having small openings; or they may burrow far and wide, and form large, empty caverns with large openings, potential caverns, for the sides mutually touch. They may be numerous. They may heal altogether or only in parts. They may bleed copiously. Their occasional

gnawing quality is often wonderfully displayed in destruction, which may remove the whole ano-perineal region, including the viscera there—the urethra, vagina, and rectum. When the uterus is affected, the peritoneum may be perforated. In *lupus minimus* there may be only little red pin-head spots, which change, healing and reappearing as months go on; or there may be a small scarcely ulcerated patch; or a little ulcer on a urethral caruncular hypertrophy, or on a coriander-seed hypertrophy on the hymen, or near it.

The hypertrophies vary as much as the ulcerations. I have never seen them so great in *lupus* of the face, or of any other part of the body. When great, they are generally ulcerated and generally on their inner sides, or where they are in contact with other parts. Sometimes the hypertrophy of a *nympha* or of a *labium majus*, or of both, has no morbid appearance or feeling except size. The same is true of the masses sometimes observed around the anus. In the case of *lupus minimus* so often referred to, the left *nympha* was, at the end of six years, unexpectedly found in this state. It presented, on histological examination, nothing peculiar, and we would not have known it was diseased had we not seen it previously like its neighbor, and now four times as big. Sometimes there seems to be a new development of *nympha*, that part not terminating at the side of the vaginal orifice but encircling it posteriorly in a copious frilled healthy-like fold. The hypertrophy may extend over the hip with or without deforming it. It may, in the pudendum, result in the production of large irregularly-lobed projecting masses. In one case we had a fantastic appearance, several rounded white masses hanging suspended by long thread-like white stalks. A large hypertrophy is generally ulcerated somewhere, but I have never seen it destroyed by such ulceration or removed. There is no doubt that in many cases the urethral caruncle is merely one of these hypertrophies.

The coloration of ulcerated parts is always red, more or less pale, or more or less deep. Other parts may have a natural brownish or red tint, or may be deep red, especially if inflamed, or they may be pearly or ivory white.

Inflammation, as I have already said, is not uncommon, more common in the neighboring mucous tracts than in the ulcerated and hypertrophied parts. In the mucous tracts the coloration is deep red, and the secretion of pus is copious. The inflammation frequently leads to stricture. Adjacent parts of skin, as between the hips, are sometimes intensely and chronically inflamed, copiously secreting pus, and this without any distinct ulceration, only a scarcely raw redness without defined edges.

The disease is often marvellously without symptoms, only the inconvenience of the hypertrophy or of the discharge, or of both. A woman with extensive ulceration may think that she has only whites, and cohabit, and bear children; or she may not suspect she has any special disease till she is seized with copious hemorrhage. But there are other cases where, without inflammation, and generally in *minimus* cases, the sensitiveness is extreme, and this great difference in cases has made me doubt the identity of the disease in them. When there is inflammation the inguinal glands may be affected, and they may, though rarely, be affected without inflammation. Of course, when parts are inflamed, we have the usual symptoms of that condition.

From cancer the disease is easily distinguished histologically; but without resort to that evidence, you will know the malignant affection by its appearance, its history, and by the early enlargement of the inguinal glands if it affects the vulva. If the disease is altogether internal, you may have great difficulty in diagnosis.

Elephantiasis is a disease affecting the clitoris or labia only, a great hypertrophy of slow growth, sometimes curiously and regularly nodulated, as in this specimen without the exedent ulceration of lupus. It is also distinguished by histological characters. I know little of it, for it is rarely seen in these countries.

There is a sort of elephantiasis seen in tertiary syphilis, of which I know very little. In cases I have seen the hypertrophy has been considerable, not at all like that of this lupus, nor like the enormous growths of elephantiasis. It is of a uniform dull leaden red color, generally smooth on the surface, sometimes superficially ulcerated in mutually touching surfaces, sometimes fenestrated, and the inguinal glands are affected.

As the lupus varies in its characters with the lapse of time, so it is natural to expect that it should be regarded as amenable to treatment; and, no doubt, great gain may come from treatment, especially surgical interference. This consists in removing hypertrophic masses, and in cauterizing ulcerations; and both these operations are best done by actual cautery; and when the galvano-caustic is available, I prefer it. I do not say you cure the disease by this means, but you have seen cases of great extent and severity very greatly ameliorated by it, the women going away believing themselves cured.

The mucous membrane inflammations are treated just as such inflammations are treated in other circumstances, but we have learned to attach special value to mercurials, using chiefly the *lotio nigra* as a wash, or applied in strips of lint. Under favorable circumstances and treatment, it is interesting to notice the softening or even disappearance of strictures caused by these inflammations.

Constitutional treatment is not to be neglected. Regulation and maintenance of general health, the use of cod-liver oil, of arsenic, and of iron.

Lupus is not a fatal disease, and few autopsies are recorded. They have as yet added nothing to our knowledge of the specialties of the affections.—J. MATTHEWS DUNCAN, *Med. Times and Gaz.*, Nov. 15, 1884.

MULTIPLE CACHECTIC GANGRENE OF THE SKIN.

THIS affection received its name from the late Prof. Simon, of Breslau, by whom, in 1878, it was also first described as a distinct dermatosis. It is comparatively of rare occurrence. During a constant connection, since the foregoing date, with dispensaries for diseases of the skin, I have treated only two cases of the kind—one in 1880, the other within the past eight days—and in the interval the complaint has not, to my knowledge, been observed elsewhere. Both of these patients were children; in fact, adults seem, so far, never to have been attacked in this way. In both instances, also, the disease pursued a very similar course. The subjects, having previously been reduced, from one cause or another, to a condition of profound cachexia, became covered with an eruption composed partly of small dark-red spots, partly of vesicles with sero-purulent contents, and partly of the characteristic deeply-penetrating ulcers, covered with a dry and blackened crust. The eyes were also affected, keratitis being present in one case and conjunctivitis in the other.

When confronted for the first time with this assemblage of symptoms, we regarded it as originating solely in the pre-existing cachexia, which we supposed had caused a thrombosis in the superficial vessels of the skin, resulting in the gangrenous ulceration. In accordance with this idea, we relied in our treatment mainly upon tonic medication combined with bran-baths and mild antiparasitic ointments. Our success was not altogether satisfactory. The cutaneous malady,

indeed, was removed in the course of six or eight weeks, but, owing to the effects of fever (from absorption), the constitutional condition remained unimproved.

Having proceeded in this instance upon a mere hypothesis, we determined, when the next case of the same kind arose, four years afterwards, to provide a surer foundation for our efforts, by making a careful microscopical examination of the ulcer and its products. This was accomplished with comparative facility, disclosing, amid the usual multiplicity of pus-cells and corpuscles, a peculiar vegetation, bearing a strong resemblance in size and character to the trichophyton tonsurans of Malmsten. The great abundance of mycelium-tubes was especially noticeable. Various-sized bacteria were also discovered in immense numbers. The conjunctivitis was likewise found to be of a mycotic nature.

I believe at present that the bacteria have nothing to do with the essential nature of the disease, but are merely accidental accompaniments of the offensive discharges from the ulcers—or perhaps their cause. On the other hand, I regard the fungoid product—trichophyton tonsurans—as its actual excitator, and consequently I look upon multiple cachectic gangrene of the skin, no longer as a simple gangrene arising from engorgement, but at a *dermatomycosis*—by which I mean, not something altogether new, in the sense of being occasioned by a newly-discovered element, but an affection due to the *accidental co-operation of various morbid influences*.

The trichophyton itself, when sown upon a moderately healthy soil, is unable to overcome the resisting capabilities of the cells with which it is brought in contact, and hence will give rise to nothing more formidable than an invasion of herpes tonsurans; but implanted in a cachectic constitution, it speedily conquers in the struggle for existence, proceeds in its destructive career until certain portions of the integument are cut off from their sources of nutrition, and in this way a condition of actual gangrene is established, with all its possible and probable injurious consequences. Many other pathological processes of this sort involve a similar termination. Thus a certain sore which is ordinarily of a benign character may, in one case out of a thousand, be converted suddenly into a soft gangrenous ulcer, and in a few hours commit almost incredible ravages, utterly destroying, for instance, a prepuce or an entire glans penis in a single day, and ultimately spreading much further. In this case, also, the victims are generally cachectic—and the same may be said of diphtheritis and gangrenous variola.

I would suggest that the name originally bestowed upon the disease we are considering be retained, but with the addition of a single term, which would make it read *multiple mycotic-cachectic gangrene of the skin*. Nosologically, I would place the affection under the head of herpes tonsurans.

If these points be now regarded as settled, they are of great significance in their bearing upon the question of treatment. After discovery of a parasite in the ulcers, I ordered for my latest patient a strong thymo-salicylic ointment and baths of soap and water—combined, of course, with appropriate invigorating remedies. These measures, continued for three or four days, produced a marked improvement in the condition of the ulcers, and the child was discharged cured in eight days—while in the previous case as many weeks had been required to bring about a much less favorable issue. The element of time is here of special importance, since, in all cases of gangrene, there is danger at any moment of a thrombosis of internal organs or of general blood-poisoning.

The eye-symptoms are never to be neglected. The early and judicious employment of antiseptics may be relied upon for the attainment of our object in this direction also.—DR. EICHHOFF, *Deutsche Med. Wochenschr.*, Nov. 20, 1884.

PAINFUL SUBCUTANEOUS TUBERCLES.

THE morbid formations thus specially denominated are of such rare occurrence that the author has met with them in only one per cent of the tumors examined daily at his histological laboratory. They are situated within the subcutaneous connective tissue, and are generally movable, though in some cases quite firmly adherent to the skin. Their size varies from that of a small pea to that of the end of the thumb. And they are round or oval in shape, occasionally somewhat flattened. Their surface is usually quite smooth. The neoplasm itself is loosely enveloped in a layer of connective tissue, which forms its bond of union with the neighboring parts. When cut open, it is found to be mainly composed of fibrils which interlace with each other in every possible direction. The color of the tumor is white or yellowish. It is of very firm consistence, resembling in this respect an adult fibroma or a uterine myoma. Its centre is sometimes occupied by a nucleus of bony hardness. As to its intimate structure, all that has been positively distinguished are smooth muscular fibres (*in immense preponderance*), a small amount of elastic fibrous tissue, and some sclerosed blood-vessels, the whole encased by a thin layer of connective tissue. The hardened nucleus is purely calcareous, and without a trace of ossification.

Painful subcutaneous tubercles may occur probably on any part of the surface, but are most commonly encountered upon the upper and lower extremities, especially the latter. The disease commences—sometimes as the result of injury—in the form of a minute swelling, whose growth is so extremely slow that it may occupy ten or fifteen years in reaching the size of a pea or a bean. The tubercle is at first quite painless, except, perhaps, when subjected to pressure. Suddenly—in some cases after the lapse of several years—it becomes the seat of pain, which in the beginning is produced only by blows or other rough usage. Sometimes these sensations retain their intermittent character, sometimes they come to be felt almost continuously and without appreciable cause, or else are excited by the slightest contact, as of the clothing, etc. They are unmistakably neuralgic, extend to a considerable distance, and sometimes acquire an intensity which renders life a burden to the patient. Professional examination of the swelling is almost always followed by an exacerbation of this symptom. The tubercles are perfectly benign, and their extirpation is demanded solely on account of the pain. Their diagnosis is unattended with difficulty, and their removal—by a correspondingly simple operation—at once puts an end to the whole trouble. It has never, or scarcely ever, been possible during the operation to discover any actual connection between the tubercle and the course of any nerve-filaments, whether large or small. Consequently, the relation which a painful subcutaneous tubercle bears to the nervous system has not been established by observation; it can only be surmised.

It is true that M. Chandelux, who has published an interesting series of articles on this subject (*Arch. de Physiol.*, 1882, p. 639 et seq.), includes under the head of painful subcutaneous tubercles *all tumors whatsoever* containing nerves sensitive to pressure. But if this conception be correct—if painful subcutaneous tubercles may comprehend different sorts of tumors—how is it that all these tubercles exhibit precisely the same symptoms? My own researches have led me to the opposite opinion, viz., that true painful subcutaneous tubercles not only present this uniform likeness from a clinical point of view, but that they all belong to a single class of tumors, *i. e.*, to the myomata, not, of course, but that *any* tumor may become painful if it incloses nerves. Daily observation shows

us this in the case of cancers, for example. But there is surely a very great difference between ordinary tumors accompanied by pain and "painful subcutaneous tubercles," the suffering arising from which is quite as pronounced and characteristic as that produced by fissure of the anus or by zona. This difference is readily explained by accepting my judgment as to the structure of the subcutaneous tubercle—a judgment in which I have been anticipated, moreover, by no less an authority than Billroth.

But, admitting the muscular constitution of the subcutaneous tubercles, how are the pains to be accounted for? As not a trace of nerve-substance has been detected in any of our specimens, we have to choose between the following suppositions:

1st. *That the tubercles contain nerves*, concealed either in the depths of the pathological tissue, or in the walls of the blood-vessels. If this be so, it is clear that spasm of the muscular fasciculi will cause pain like that experienced in cramps and colics or from compression of an arteriole. As the tumor develops and exerts more contractile force, these pains increase; they are more or less intermittent, like all muscular pains, and, like all such pains, they are excited by various external agencies.

2d. *That the tubercles contain no nerves*. In this case, when the tumor contracts and becomes round and hard, it compresses the cutaneous nerves in its vicinity like a foreign body. We know how keenly sensitive is the integument to any normal contraction of the *arrectores pilorum*. If, therefore, as is probable, the subcutaneous myoma is developed at the expense of these little organs, we can understand what severe pain they must occasion under the influence of the morbid process; and the fact that this pain is excited by muscular contraction will account for its intermittent and paroxysmal character.—A. MALHERBE, *Gaz. Méd. de Nantes*, Oct. 9, 1884.

TWO CASES OF LICHEN PLANUS

IN WHICH THE ERUPTION WAS DISTRIBUTED ALONG THE COURSE OF CUTANEOUS NERVES, WITH REMARKS ON THE INFLUENCE OF THE NERVOUS SYSTEM IN THE DISPOSITION OF CUTANEOUS ERUPTIONS.

THIS formed the subject of a paper by Dr. Stephen Mackenzie before the Harveian Society of London. The author narrated the case of a woman in whom lichen planus was arranged round one-half of the back and abdomen in belt form, like herpes zoster, for which the eruption had been mistaken. Later the eruption became generalized. There was intense itching of the skin, and white patches on the buccal mucous membrane. In the second case, also that of a woman, the eruption was confined to a track down the inside of one arm corresponding with the internal cutaneous and ulnar nerves, with intense itching in the area of the eruption. Dr. Mackenzie proceeded to point out that these cases were deviating from the ordinary type of lichen planus, which was characterized usually by marked symmetry. He next drew attention to other cutaneous diseases which were distributed along the course of nerves, as herpes zoster, morphea, neuropathic papillomata, purpura, etc. He next considered the anatomical evidence explaining such neurotic eruptions, and by the kindness of Mr. McCarthy, was able to show to the members a microscopical specimen of the spinal ganglia of a case of retroceding zona. He then dealt with the significance of such eruptions, indicating his belief that the local lesions of the nervous centres merely determined the localized eruption, and that there was some other factor

which decided its nature. He instanced some observations of Dr. Moxon, in which the local development of tubercle, cancer and pleurisy were determined by local affections of nervous centres. He then passed in review the circumstances which occasioned symmetry of eruptions, showing that local tissue peculiarities could not be left out of consideration, and that asymmetry rather than symmetry was characteristic of eruptions directly due to local diseases of the nervous system. He thought that symmetrical eruptions like lichen planus and psoriasis were due to some general nerve influence, or diathesis, the symmetry in such diseases being in part due to local tissue influences; and that cases such as he had narrated did not support the view that the ordinary symmetrical distribution was the direct outcome of nervous influence.

DR. MALCOLM MORRIS said that cases of localized lichen planus, like zoster, were very rare. He referred to a communication in the *New York Medical Record* by Dr. Robinson, in which lichen planus and lichen ruber were described as two diseases, the former being the most localized. Mr. Morris thought on the whole that lichen planus was probably neurotic and not a blood disease, as it often developed in persons who were severely depressed. He mentioned the case of a lady, aged fifty, whose husband died suddenly abroad. On her return to England she was, after a few days, attacked with general lichen planus, accompanied with intense irritation and other nervous symptoms. She gradually recovered as the depression passed off, under the influence of arsenic and complete rest. This pointed to the disease being a nerve storm like megrim, with cutaneous manifestations.

DR. COLCOTT FOX remarked that modern researches had accumulated a mass of evidence to show that the nervous system played a very prominent part in the evolutions of skin diseases, either directly through trophic nerves or through the agency of the vasor-motor system. From anatomical considerations it was evident that if a morbid influence was exercised through the vaso-motor nerves, the areas occupied by the eruptions would correspond with the areas of blood supply. It was difficult to resist the conclusion that the corymbose patches of eruption seen in a great many affections of the skin were thus caused. It was still more impossible to resist the conclusion that the patches of shingles were developed on the trajectory of a nerve, and indeed this had been placed on sure ground. From the mass of evidence to hand he might point to the evidence of nævi, both blood-vascular and papillary, in relation to nerve distribution, and this brought him to speak of continuous lines or narrow bands of eruption which were usually ascribed to nerve influence though more difficult to account for at first sight. Such bands he had described in 1880 as occurring in slight asymmetrical cases of lichen planus, and these were now confirmed by Dr. Mackenzie. As to the etiology of lichen planus, he had been schooled in the theory that it was a neurosis, from the constitutional symptoms present, and his experience led him more and more to adopt this theory.

In reply DR. STEPHEN MACKENZIE said that he quite agreed with Dr. Colcott Fox as to the neurotic nature of lichen planus as had been so well pointed out by the late Dr. Tilbury Fox. The gist of his paper had been to show that the affection of the nervous system was of a general kind, but that the distribution of the eruption was not so much determined by nervous agency as was supposed. Where the direct influence of the nervous system was undoubted, the eruption tended to have an unusual or unsymmetrical distribution.

CHANCROIDAL BUBOES.

M. STRAUSS recently made an important communication to the *Société de Biologie* upon chancroidal bubo. It has been generally admitted that chancroid may give rise to a simple bubo with non-inoculable pus, and to a virulent bubo with inoculable pus.

M. Strauss examined at the Hôpital du Midi the pus of forty-two buboes originating from chancroids. These buboes were in different stages of evolution, but all containing pus. After having sterilized the skin by washing, Strauss opened the bubo, took the pus and examined it. In none of these forty-two cases did he succeed in coloring and demonstrating the presence of micro-organisms. This, in particular, would lead him to recall the conclusion which he had formulated, that there are always micro-organisms in phlegmonous pus. The *bouillons* which he had sown with this pus all remained sterile. He had, moreover, practised inoculations with this pus with negative results, even when the inoculations made at the same time with the pus of the generating chancroid gave positive results. Finally, in isolating the bubo at the moment of opening it from all contact with the chancroid by means of a disinfecting cotton and a spica, without using any antiseptic agent the buboes always behave as simple buboes—they never became virulent.

M. Strauss concludes that when the bubo of a chancroid becomes virulent, it is because the wound of incision has become contaminated by the secretion from the chancroid itself. The virulent bubo will then completely disappear when sufficient care is taken to prevent the contamination of the bubo by the chancroid which occasioned it. In a more recent communication before the Société de Chirurgie, M. Horteloup takes exception to the conclusions of M. Strauss. After referring to the importance of diagnosing the two forms of adenitis, the simple inflammatory and the virulent, he says that the virulent bubo has ordinarily a particular march and aspect which leads one to suspect its character, and that certain chancroids would appear to more particularly predispose to it by their anatomical situation.

But in the history of chancroidal bubo one point remains obscure. When inoculation is made at the moment of opening into the pus of a bubo, which will later become chancroidal, the result is very exceptionally positive; but twenty-four or forty-eight hours after incision or spontaneous opening, the inoculation gives a positive result.

To explain this bizarre fact, Ricord admits, in the suppurative adenitis consecutive to a chancroid, two kinds of pus; one superficial, phlegmonous, due to a peri-adenitis, the other profound, developed by the transport of the virus from the chancroid into the ganglion by the intermediary of the lymphatics: the difficulty of securing the virulent pus at the moment of the incision being the cause of the failure of the inoculation.

According to others, the virulent pus is, so to speak, overwhelmed in the midst of the phlegmonous pus, and it is necessary to await the inoculation of the entire ganglion, which being transformed into a veritable chancroid, will then produce a virulent pus.

M. Horteloup believes that there occurs in the interior of the ganglion a veritable gangrene which momentarily destroys its virulence, but which is regained after the elimination of the mortified parts.

He finds it difficult to admit the theory of M. Straus, in the case of virulent buboes occurring in individuals whose chancroids were cured at the time of open-

ing the bubo, and when transport of the virus to the wound was not possible. M. Ricord has recorded seven such cases, and he himself had reported one.

M. Horteloup concludes that, while virulent bubo is certainly less frequent than certain statistics would lead us to suppose, it unfortunately exists.

There should be a reaction against the tendency of certain surgeons to too readily believe in the non-virulence of buboes consecutive to chancre, and give a benign prognosis which the future course of the bubo, even when treated by occlusion, would not verify.—*Le Progrès Médical*, Nov. 29, 1884, and *L'Union Médicale*, Dec. 23, 1884.

GONORRHOEAL ERYTHEMA.

DOCTOR RAOUL MESNET proposes to demonstrate in his thesis: 1. That true copaiba erythemas are much rarer than have been supposed. 2. That under this name have been included a large number of cutaneous manifestations due to another cause. 3. That the greater number of these eruptions depend alone upon the gonorrhoea itself—an infectious malady.

In the first part of his thesis, M. Mesnet calls attention to the fact that copaiba has been employed in a large number of different affections without giving rise to copaibal erythema, or at least quite exceptionally as has been observed in the experiments made with it in the treatment of psoriasis. On the other hand, as Bazin has pointed out, the duration of the roseola of copaiba is by no means subordinate to that of the medication. M. Rodet, for example, has vainly continued the use of copaiba in order to maintain and prolong an eruption which he desired to exhibit. It disappeared notwithstanding the potion of Chopart, and for a long time M. Besnier, every time he meets with an eruption of this kind, does not discontinue the treatment, but, on the contrary, often increases the dose of copaiba and notwithstanding this practice the eruption disappears quite as rapidly.

In the second part of his thesis, M. Mesnet cites cases in which the eruption occurred without the patient having taken any medicine. He cites the remarkable case of M. Ballet in which a scarlatiniform eruption developed in the case of a gonorrhoeal patient, with typhoid phenomena and marked febrile symptoms. An analogous case has already been published by M. Balzer. M. de Molines has also observed a scarlatinal eruption in a gonorrhoeal patient who had not taken any kind of medication. From these cases, and many others of the same character, the infectious nature of gonorrhoea seems absolutely demonstrated.

These eruptions, while variable in their aspect, can only be considered as an expression of a general infection. Their most common form is a scarlatinal or rubeolic erythema, but there may be likewise observed urticaria, polymorphous erythema, purpura and furuncular eruptions; these accidents, however, do not appear to possess any gravity.

As to the physiological explanation of the production of these cutaneous manifestations, it would be premature to give it as definitive. Since, however, the existence in the economy of a special microbe of gonorrhoea seems to be absolutely demonstrated, one may ask if these dermatopathies are not the effect of the presence of these microbes in the skin, which would then become a centre of elimination of the infectious agents.—*Journal de Médecine et de Chirurgie*, Dec., 1884.

THE USE OF POWDERS.

DR. MALCOLM MORRIS thus speaks of the practice of powdering: But when a decree has gone forth that powder is to be applied to the cheeks from morning to

night to the utter destruction of the complexion, it is time to speak out, and that it does so destroy it is attested at this moment by thousands of skins puckered and pitted, that but for using powder would have remained to this day soft as silk. The constant use of powder has precisely the same effect on the glands of perspiration as the overstraining of the voice has upon the throat of a clergyman or public speaker. With the continuous exertion to secrete moisture to lubricate the throat, the glands become exhausted and give out so small a supply that, if speaking be persevered in, an obstinate complaint termed clergyman's sore throat is the result. So with the glands of perspiration in the face, as the powder dries up the moisture, more and more is secreted, till the glands become at last unable to fulfil the unavailing task, and shrinking, produce the little chasms that give the orange rind appearance that is but too familiar to all observant people. As in the petal of the flower and on the wing of the butterfly, there is always a delicate down that no powder can simulate and any excess of this is a disease.—*International Health Exhibitions Lectures*, 1884.

THE TREATMENT OF RINGWORM OF THE SCALP.

SINCE May or June, 1881 (when I was officiating civil surgeon of Backengunge, Eastern Bengal), I have been in the habit of treating cases of Indian ringworm with a solution of Goa powder in pure chloroform, painted over the patches daily. I have found this method very efficacious in curing the ringworm, though at first causing a sensation of intense burning pain (especially when applied to parts where the skin is tender, as the inner side of the thighs, scrotum, arm-pits, etc.; yet as this pain was very transient, it did not deter me from using it, and my patients did not complain. Probably a solution of pure chloroform alone would cause just as much pain if applied to tender parts. Goa powder is very imperfectly soluble in chloroform, and it is as well to shake the bottle containing the chloroform-solution well before using. I generally use a supersaturated solution. The Goa powder, or araroba, contains, according to Martindale and Westcott, eighty per cent of its weight of chrysarobin or chrysophanic acid (also see an analysis of Goa powder in the *Pharmaceutical Journal* for 1875). Since the earliest part of 1882 I have frequently used the chloroform-solutions of Goa powder for patients in the European General Hospital, and always keep a supply ready.

I think that the impalpable yellow precipitate of chrysarobin left after the evaporation of the chloroform, and which adheres pretty firmly to the skin, is infinitely preferable to the ointments and pomades containing Goa powder, which are sold in this country.—GEO. F. A. HARRIS, M.R.C.S., L.R.C.P. Lond.—*Brit. Med. Journal*, Jan. 24, 1885.

BLÉNORRHAGIC FOLLICULITIS IN WOMEN.

GNORRRHŒAL urethritis and vaginitis are most frequently attended with folliculitis.

This folliculitis may persist a long time after the vagina and urethra have regained their normal condition. It is often the cause of errors of diagnosis, moreover; it often passes unperceived, and in this case the gonorrhœa remains unrecognized.

The structure of the follicles is that of glands *en grappe*. Under the influence of exciting causes, even when the vaginitis and urethritis have been long cured, the folliculitis may re-develop and propagate the gonorrhœa.

Chronic inflammation of the intra-urethral follicles may lead to hypertrophy of their elements and give rise to small polypiform tumors.

The peri-follicular cellular tissue, under the influence of a new irritation, may become inflamed and suppurate. In this case an abscess is formed. This abscess may result in fistulæ.

Gonorrhœal folliculitis cannot be cured by the means ordinarily employed in the treatment of vaginitis and urethritis. It is necessary to destroy the follicles locally, and this can be accomplished by an energetic cauterization, the galvanocautery for example.—DR. E. BAUCHET, *Thèse de Paris*, 1884.

CONTRIBUTION TO THE STUDY OF GUMMOUS PERIOSTITIS OF THE SCAPULA.

GUMMOUS periostitis of the scapula is circumscribed or diffuse. The latter variety is rarer than the former.

It appears in the tertiary stage of syphilis. From a clinical point of view, it presents itself under three forms: *a*, under the form of a dry gummous tumor; *b*, under the form of an abscess; *c*, under the form of osteo-sarcoma.

Gumma of the scapula consists of tumors slow in their evolution, indolent, and but slightly painful. Their volume is variable, but scarcely surpasses that of the two fists. Their development is characterized by two quite distinct phases, one of crudity, the other of softening gummous periostitis. It may undergo resolution, either spontaneously or under the influence of treatment. It may be the starting-point of exostosis, hyperostosis, or terminate in suppuration.

The scrofulous diathesis seems to favor this suppuration.

The diagnosis is oftentimes quite difficult, and demands a great perspicacity on the part of the surgeon. Gummous periostitis, in fact, sometimes presents all the characteristics of a cold abscess, of a scrofulous gumma, or of an osteo-sarcoma.

In general, specific treatment is not slow in producing the complete disappearance of the lesion.—DR. FOLLIOT, *Thèse de Paris*, 1884.

THE INFLUENCE OF CERTAIN SYPHILITIC LESIONS OF THE UTERUS UPON LABOR.

SYPHILIS may be the cause of dystocia, by the alterations which it produces in the structure of the neck of the womb.

The induration which sometimes accompanies cervical chancre, which follows it, or which may occur without other local accident at the same time that crops of secondary accidents appear upon other portions of the body, is a cause of rigidity of the borders of the uterine orifice.

In these cases, where microscopical examination has been practised, the lesion was found to be constituted by a rarity of the bundles of smooth muscular fibres, and by the predominance of a dense, compact, fibrous tissue, infiltrated with lymphoid cells. It was, in fact, a chronic inflammation of the cellular tissue with chronic lymphitis.

Rigidity of syphilitic origin is easily recognized by the history of the case, by concomitant lesions, and by its objective characters.

Treatment by baths, by warm douches upon the cervix, the local application of extract of belladonna is generally without avail. Incisions of the cervix should be practised when the condition of the mother and the child indicates it.

Properly performed, the operation is generally without danger. The only death which has occurred after the incisions was not due to the operation.—DR. MESNARD, *Thèse de Paris*, 1884.

Received.

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Psoriasis-Verruca-Epithelioma : A Sequence. By JAMES C. WHITE, M.D. (Reprint.)

Items.

SOLUTION FOR ORCHITIS.—Acide [Phénique, 9 grams; Alcohol, 1 gr. Dissolve. By means of a brush dipped in this solution, the integument of the inguinal canal over the course of the painful cord should be painted three or four times with intervals of a few seconds between each application. A sharp burning results which should be allayed by cold compresses. In the case of severe orchitis with funiculitis, this painting should be repeated the third or fourth day. This mode of treatment, according to the author, reduces the duration of the affection to eight days or less. A single cauterization suffices in some cases to arrest the orchitis.—DROUET, *L'Union Médicale*, No. 140, 1884.

GRAY PLASTER (SIGMUND).—R Emplastrum Hydrarg.; Emplastrum Saponis, āā 30 grams. Melt with a gentle heat and spread upon a cloth. This plaster may be applied to tumors of syphilitic origin, upon papules, vegetations, fissures of the same nature, upon indurated testicle, etc. It may be formed into bougies or suppositories and introduced into the rectum or urethra in cases of syphilitic induration.—*L'Union Médicale*, No. 149, 1884.

IODIDE OF POTASSIUM FOR PSORIASIS.—Dr. Greene, director of the hospital in Christiana, recommends large doses of iodide of potassium in the treatment of psoriasis. The dose is gradually increased until it has reached 15 grains three or four times a day; the effect on the eruption is visible. As the dose is still further increased, the improvement is rapid. No local treatment is used.

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Original Communications.

THE RELATIONS OF SKIN DISEASES TO MARRIAGE.¹

BY

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MARRIAGE and syphilis has been so thoroughly discussed and so much attention has been paid to it, not only by syphilographers, but by the profession in general, that all the phases of the question have been considered. Despite this, all authorities are by no means united in their conclusions, although all agree that, during certain stages of the disease, marriage is entirely precluded. That syphilis is hereditary and transmissible is acknowledged by all who have had any experience whatever in the observation and treatment of the disease. Those physicians who have paid any considerable attention to insanity and affections of the nervous system, claim for many forms of the neuroses if not a direct transmission, at least a hereditary tendency to the same or allied forms of nervous lesions, derived from one or both parents. Rheumatism, gout, hemophilia, phthisis, and a number of other general affections are accused by a number of experienced writers to have that power in them by which the parent will hand down the peculiar susceptibility to those diseases, to his unlucky progeny. On the other hand, some very respectable authorities deny heredity as such, whilst acknowledging that the physical weakness is perpetuated.

A few of the more common, and at the same time most troublesome, diseases of the skin will be briefly noticed in this paper, and an attempt made to point out the probable chance of their reappearing in the off-

¹ Read before the St. Louis Medical Society, April 4, 1885.

spring, together with the reasons why patients suffering from certain dermatoses should, if not entirely give up marriage, at least postpone that relation until circumstances justify such a course. As a prefatory remark it may be stated that it is not necessary for the mother or father to be the recipient of the trouble from the consort in order that the child may be the subject of the disease.

It is not the local manifestation of the disease that constitutes the active factor, but rather the general condition of the entire economy of one of the progenitors, which has undergone certain more or less profound changes which manifest themselves more or less distinctly upon the external surface of the body, as a sort of danger signal; and, generally, there are certain appearances connected with these lesions that, to him who can read, constitute a fair index of the severity of the existing condition.

It is manifestly obvious that a person suffering from an infectious or contagious disease should not marry during the active period of the trouble. No one afflicted with any one of the parasitic diseases would object to submitting to a proper course of treatment before marrying. But there are some troubles of the skin which, although we may admit that they are neither contagious nor directly transmissible, or only rarely so, are sufficiently dangerous, in this respect, to awaken our attention and deserve more study. It will be noted that the extreme views of the French and German schools of dermatology have been avoided, as we are not willing to admit, upon the one hand, the universal constitutional nature of all dermatic affections; nor will we, on the other, concede that they are all purely local and due, almost without exception, to external causes alone. For this reason, whatever authorities we have consulted are chiefly those occupying what we consider the most rational position, which is one situated midway between the two extremes, and from those who are willing to let theory bend to facts.

The object of these few remarks is not so much to uphold a theory as to inquire whether there may not be enough in the question of the heredity of skin diseases or the predisposition thereto, to make it of some moment to the medical practitioner who may be questioned as to such being a bar to marriage.

Eczema is by far the most common, and, unfortunately, it often becomes the most intractable of the troubles afflicting the skin. When first studied the disease was for a long time regarded as purely local; then it was admitted by a large number that it might be somewhat dependent upon internal causes. Its heredity was denied *in toto* at first. We find that, later on, in speaking of the etiology of this protean disease that some authors acknowledge having seen a few—a very few—cases, which they considered hereditary. The latest work on the subject and

one which we, as Americans, are proud to point to, is Bulkley's sterling work. He says:¹ "But, on the other hand, although the disease appears to come by direct inheritance in but a very few cases, it is still true that in a certain number it is seen to be hereditary, and whole families are sometimes affected, not only in one generation but in several." . . . Again, "Scrofula or struma undoubtedly appears as a predisposing cause of eczema in the way of inheritance, quite as effectually as when existing in the individual." Van Harlingen, Piffard, Liveing, Duhring, E. Wilson, and even Neumann acknowledge that, in some cases, this disease is undoubtedly hereditary. There is also a greater probability of its being transmitted, if it exists as an old chronic and intractable form of the disease in the parent.

The next most common affection which we meet with in practice is, no doubt, psoriasis. This disease is acknowledged by all authors of any prominence to be hereditary. It is contended, however, by a number of recent observers that the heredity is more marked, or more liable to be seen, if one or both parents have had the disease in a marked and recurrent form. In those cases in which it assumes the "universal" form, it is pretty certain that the offspring of the affected parent will either exhibit the same disease, or some allied cutaneous affection.

Lupus vulgaris, whose pathology is as yet involved in more or less obscurity, is another one of these dermatic affections which would seem to be transmitted from parent to child. We will not inquire whether the neoplasm which constitutes it is scrofulous, tubercular, or of some other origin. Any one of these causes is sufficiently impressed upon the constitution of the progenitor to involve that of the progeny by direct inheritance.

Ichthyosis, especially of that variety known as "ichthyosis hystrix," is undoubtedly a hereditary affection, or, rather, deformity. There is no single author who has ever observed any number of cases, limited though it be, who has not immediately had his attention called to this important fact. It would be useless here to advert to the *dicta* of the many dermatologists who have expressed an opinion upon the subject. The disease is undoubtedly the most markedly hereditary one with which we are acquainted.

Lepra, or true leprosy, whether it be dependent upon a bacillus or not, is transmissible from parent to child. Although no well-authenticated cases exist to show that it has been acquired by contagion, or that its bacillus has been successfully inoculated, examples of its occurrence in families which have continued leprosy for several generations are numerous and well attested. Whether the primary cause be climatic or parasitic, the fact of its heredity remains.

¹ Second Ed., p. 93.

Chronic pruritus has been observed in a mother, her daughter and granddaughter, as detailed in the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, February, 1885, by Dr. Wm. J. Maynard. An interesting fact in connection with this is that the male members escaped.

Sarcoma and carcinoma of the skin are further examples—of a malignant type of disease—of dermatoses which are transmissible from generation to generation.

The writer has observed cases of vitiligo in which the trouble was transmitted to the offspring apparently. Not only was there a reappearance of the disease in the children, but all were affected in a manner similar to that of the parent, and identical parts were the first to be involved in the process.

We know well that the color of the skin is very susceptible of being transmitted to the children, and we daily observe such as the results of mixed intercourse. Each race has certain pigmentary peculiarities of the skin, which, by some process or other, seem to be stamped upon the child to a greater or lesser degree. In certain families we find that a lock of white hair in a particular locality is transmitted from generation to generation, just as other peculiarities or deformities are. Often, again, whole generations escape, and the "sign" reappears upon a remote descendant, showing that although this peculiar force may become latent, it does not necessarily lose any of its strength on that account, as all those acquainted with the facts of atavism know.

A cursory glance at these various examples would seem to indicate that heredity plays but a very unimportant part in the genesis of skin diseases. But when we take into consideration the small amount of care taken, not only to trace diseases back to their origin, but also the inability to follow the various successions through different generations, the amount of evidence offered acquires more force than would be at first accorded to it. Besides this, the cause can often be recognized as being some condition which has shown itself in different ways, and only evidence itself as a skin disease in the last member of a long line of individuals. Were our observers to pay more attention to this subject, there is no doubt whatever that the rôle played by heredity would be found to be much more important than it is regarded at the present time.

As a natural conclusion it will follow that, if certain skin diseases are directly transmissible, or if the causes thereof are, marriage between individuals affected with these troubles, whether the disease be confined to one or both of the high contracting parties, should be very carefully considered, if not prohibited. Before permitting such an union to take place, the dermatic genealogy should be carefully examined, and all the possibilities conscientiously weighed. The intention of this paper is rather to call attention to a few isolated facts, and to direct observation

to a new point in connection with the etiology of skin diseases which may prove serviceable in the prevention of a number of the most intractable and chronic affections which afflict the human skin. There is no doubt whatever that the more these relations are sought after the more often will they be found, and enable the physician to give safe and reliable advice in those cases where it will be needed or sought.

ETIOLOGY AND PATHOGENESIS OF DRUG ERUPTIONS.

BY

P.¹ A. MORROW, M.D.

(Concluded from p. 110.)

IN studying the pathogenesis of drug eruptions, we are embarrassed by a lack of definite knowledge respecting the physiological action of drugs. Certain of these eruptive disturbances are apparently an expression of the specific action of the drug upon the cutaneous tissues, as much so as are its other physiological effects upon the general system; while the anomalous eruptions must be considered as an aberration of the drug's normal action, the deviation from the typical mode of action being determined by the forces of the organism through which it operates.

If we know little of the laws of drug action, we know still less of the laws which govern individual susceptibilities. We do know that in the antagonism between these forces, the latter is often dominant and supreme, and that the effects of drugs are especially subordinate to conditions of aptitude inherent in the individual. Leaving out of consideration for the present that mysterious factor expressed by the term idiosyncrasy, let us examine the various theories which have been put forward as to the mechanism of the production of these eruptions.

In the first place, it may be said that an explanation of these incidental cutaneous phenomena has been sought for in the *quality of the drug*. It was naturally inferred that the production of unusual drug effects must be caused by an impurity of the agent used, due to its faulty mode of preparation or its accidental admixture with toxic principles, etc. With this view, other preparations of the same drug have been substituted, the alkaloid for the crude drug, and *vice versa*, with the result of the production of identical irritant effects upon the skin. So that the assumption of a possible impurity of the drug as the efficient cause of these irritant effects upon the skin must be dismissed as groundless and disproved by careful experimentation.

The theory which has been adopted by most writers on this subject is, that a large proportion of these eruptions are caused by the elimination of the drug through the skin.

The theory of the elimination of drugs through the cutaneous glands is based upon the assumption of the existence of one of two conditions as determining causes: 1. Impairment of the integrity of the eliminating organs. 2. Elective affinity of the drug for the constituent elements of the glands.

The hypothesis of the impairment of the integrity of the eliminating organs as a determining cause, is based upon the view that since almost all drugs introduced into the system are normally eliminated by the kidneys, when from any cause this channel of egress is blocked up, the skin by virtue of its vicarious functions attempts to perform the work of the kidneys, and the drug in its passage through the cutaneous glands causes irritation, which is manifested by various lesions. This theory, which has been urged with some plausibility by Farquharson, seemed to gain support from clinical facts. Several cases were cited in which the use of the bromides and iodides caused severe cutaneous disturbance and the patients were found suffering from renal inadequacy and cardiac lesions. But further clinical inquiry has not demonstrated a relation of cause and effect between severe renal disease and a special liability to a determination of drug action towards the cutaneous surface, even where the pathological alterations were of such a nature as to incapacitate these organs for the proper performance of their functions.

This theory pushed to its legitimate conclusion would attribute all drug eruptions to cumulative action, on the principle that introduction should in all cases be compensated for by elimination—the maintenance of this equilibrium being the condition of normal drug action. In other words that “saturation of the system” with a drug must occur as a preliminary or necessary condition of the production of its incidental effects.

This assumption is, however, abundantly disproved by clinical facts. We find that the smallest dose of a drug will, in many individuals, promptly produce the most violent tegumentary disturbance, while in others, massive doses of the same drug may be continued during long periods with absolutely no effect upon the cutaneous surface, the result being entirely independent of the *quantity* of the foreign element circulating in the blood. In the analogous cases of eruptive disturbance *ab ingestis* we recognize that it is the quality, not the quantity, of the irritant that offends.

Another phase of the “saturation of the system” theory is that the foreign material accumulates until nature, unable longer to tolerate its presence, concentrates her forces and makes a grand parturient effort to expel the offending material through the cutaneous pores, and in this

process the skin suffers various lesions of continuity. This theory is akin to the now obsolete one which recognized in the roseola of syphilis, and the exanthem of the specific fevers, an evidence that the poison had been driven to the surface and was in process of expulsion.

The second hypothesis is that drugs have an affinity for special anatomical elements, and that, by virtue of this selective action, certain drugs are attracted towards the cutaneous glands. Physical and chemical evidence of this pathogenetic mode is furnished, it is claimed, in the anatomical seat of certain lesions, as the sebaceous glands in iodic and bromic acne, and in the demonstrated presence of the drug at fault in the lesions which it has caused. No absolute proof that either of these conditions is a constant occurrence has been adduced. While the follicular apparatus may be incidentally involved in any morbid process affecting the skin, there is no evidence that it is the exclusive seat of these lesions.

On the contrary, careful and minute investigations into the anatomical seat of iodic and bromic lesions have shown conclusively that, in many cases at least, the sebaceous glands were unaffected. Drs. Thin and Duckworth concluded from their investigations of iodine lesions that they were not of the nature of acne; microscopical examinations showed no implication of the sebaceous glands and hair follicles. Negative evidence is also found in the fact that these lesions occur in cicatricial tissue, and in regions where sebaceous glands do not exist. Other observers have furnished positive proof that these lesions are of the nature of a localized dermatitis, in which the glandular structures may be healthy, or only incidentally involved.

Proof of the second proposition is sought for in the fact that the drug has been found in the contents of certain lesions, detected in the act, so to speak. But absolute proof of the production of these lesions in this way cannot be adduced. So far from being a constant phenomenon, we are justified in regarding it as a mere accident or coincidence, since numerous observers have failed, even with the most carefully conducted tests, to detect the presence of the drug in the cutaneous lesions, while it was freely found in the urine. If the elimination of the drug through the glands be the cause of the disturbance, its presence should be a constant feature. Again, if the matter were reduced to a simple chemical combination between a certain drug and the glandular elements, then this action should take place every time and in every case where these two factors were brought into contact. On the contrary, instances are exceedingly rare in which such a reaction could by any possibility be alleged.

Trousseau sought to establish an identical pathogeny for sudoral and drug exanthemata, claiming that both were caused by a modification in the composition of the sweat, which took on an irritant quality, and in its

passage through the cutaneous excretories, betrayed this irritation by a variety of pathological lesions. But proof that these lesions are not caused by an irritant and exaggerated sudoral secretion is found in the fact that two drugs, opium and belladonna, both produce a scarlatiniform eruption. The specific action of one is to stimulate the functional activity of the sweat glands, while that of the other is to diminish or suppress this function altogether. Further proof that eruptive disturbances are independent of the functional activity of these glands is furnished by the fact, that the existence of the condition known as unilateral sweating does not modify the symmetrical development of a drug exanthem. In a number of such cases reported, there was no difference in the rash on both sides.

Admitting that the eruptive disturbances which follow the ingestion of certain drugs are the result of modifications in the glandular tissues, associated with increased functional activity, we see in this only an evidence of the direct influence of the drug upon the special nerves which regulate the secretory functions of these glands. Recent physiological research has demonstrated the existence of special secretory fibres, which are distributed to the salivary and sweat glands, and which regulate their functional activity independent of conditions of hyperæmia. It has been conclusively shown by Sartisson that the absorption and elimination of iodine by the salivary glands, for example, is due "not to chemical affinity of the drug for the substances of which the gland is composed, but to nerve influence alone," so that either functional or structural changes in the sweat glands point to a disordered innervation, the determining cause of which must be sought for in the action of the drug upon the special nerves which supply these glands.

The "elective affinity theory" must therefore be dismissed as improbable. There is no evidence that the cutaneous glands or other tissues of the body exert any influence upon drugs which is at all of the nature of attraction.

Behrend classes drug eruptions under the title of "Hematogenous Exanthemata," on the theory that they are for the most part due to changes in the blood susceptible of clinical demonstration. He assigns special prominence to what may be termed the dynamic theory. He asserts that all drug eruptions, with the exception of the erythemas caused by the specific action of belladonna, hyoseyamus, stramonium, and perhaps arsenic, and the acneiform and pustular eruptions commonly seen after the use of the bromides and iodides, more rarely after arsenic, are caused by the dynamic action of drugs. This effect, he claims, is entirely independent of the physiological and therapeutical action of the drug, but due to the agency of a foreign material, probably of chemical

nature, generated in the blood by reason of the presence of the drug in the system.

Whether this foreign material is produced by catalytic action or the result of direct combination with the drug with a hypothetical substance in the blood is not specified. It is singular that this mysterious clinical compound should be so potent for mischief and yet so indefinite in substance that its detection transcends our powers of analysis. This hypothesis seems as fanciful as it is utterly untenable. It is merely a modification of the old humoralistic view which attributed all pathological alterations to a dyscrasic condition of the blood. Besides, this theory is irreconcilable with clinical facts. If the changes in the skin be caused by a changed blood mass, they should not be confined to restricted localities, as is often the case, but should be manifest everywhere the blood circulates.

We come now to a consideration of the theory of the neurotic origin of drug eruptions—a theory which recognizes the intimate dependence of all cutaneous changes, whether slight and transient, or more profound and persistent, upon disorders of innervation.

While, at first glance, it may appear inconsistent to group together eruptions so multifarious in form and character, and attribute the same pathogenetic mode to drugs widely varying in their physiological action, yet there are many considerations which force us to the conviction that it is in the sphere of the nervous system that we must look for an explanation of these phenomena. In the light of our present knowledge respecting the primary action of most drugs upon the nervous system, such a pathogenesis of these eruptions is not only conceivable, but, reasoning from analogies with other cutaneous phenomena the neurotic origin of which has been demonstrated, it appears extremely probable.

In studying the symptomatology of drug eruptions, we find that a large proportion present the characters of simple cutaneous congestions, associated with sensory disturbances more or less severe. Usually the nervous symptoms precede the development of the exanthem.

These congestions appear suddenly, and may affect only certain cutaneous regions, or they may become generalized, according as the disordered innervation is limited to particular vascular areas or affects the entire cutaneous vascular system. The character of the changes impressed upon the skin will depend upon the blood-stasis, whether it be transient or prolonged and intense.

In some cases, no doubt, these congestions are purely reflex phenomena, the point of departure of which is irritation of the sensory nerves of the gastro-intestinal mucous membrane. They are analogous to urticaria ab ingestis, and reflex changes in the skin from irritation of a peripheral nerve, as in traumatism. Besnier attaches considerable

importance to this pathogenetic mode, and proposes to circumvent it by introducing the drug hypodermically. Unfortunately for this theory, it has been proven that the dermatopathic effect is, in the case of most drugs at least, entirely independent of the mode of their introduction into the economy. It is probable that irritation of the terminal filaments of the pneumogastric accounts for but a small proportion of these cutaneous disturbances.

The large majority are consecutive to absorption of the drug, and due to its specific action upon the peripheral nerves or nerve centres. Whether this influence be exerted primarily upon the vaso-dilator or the vaso-constrictor nerves, the ultimate effect is vascular dilatation, and if the congestion be sufficiently intense, exudation. We recognize the erythematous and urticarial eruptions of arsenic, belladonna, bromide of potassium, chloral, copaiba, digitalis, hyoseyamus, opium, morphia, quinine, stramonium, salicylic acid, etc., as angio-neurotic phenomena, caused by the specific action of the drugs in question upon the vaso-motor system.

The similarity in these eruptions to other cutaneous phenomena, the nervous origin of which is recognized, would argue similarity of pathogenetic mode. It is now accepted that the roseola of syphilis, the prodromal rash of variola, the exanthem of measles, scarlatina, typhoid fever, etc., are due to the direct action of an irritant, the specific virus of the particular disease, upon the centres which preside over vaso-motor innervation. We may reasonably infer a like nerve influence in the production of erythemas from drug action. The assertion made many years ago by Wilson that "the influence of the vaso-motors are involved in the production of all roseolas," may be extended to embrace all cutaneous phenomena of a simple congestive character.

The more fugitive forms of drug hyperemias present many striking analogies both in form and localization with that large class of eruptions known as mental or emotional congestions, doctor's rash, which is so constant a phenomena in the examination of nervous females, *erythema pudoris*, etc. These are pure angio-neuroses dependent upon an impression emanating from the emotive centres.

Clinical analogies with drug eruptions may also be found in traumatic, septicæmic, and menstrual eruptions, the *taches cérébrales*, tabetic ecchymoses, etc., occurring in cerebral and spinal diseases, and which are absolutely inexplicable except on the theory of their neurotic origin.

We have seen that in many cases the severer forms of eruptive disturbance are the outgrowth of the simpler, the grade of the eruptive element depending upon the continuance of the morbid stimulus. There are certain other cases, however, in which the eruption is only developed after the more or less prolonged use of the drug, the structural changes having a definite relation to the size and continuance of the dose, such

as the severer forms of the bromide and iodide eruptions, for example. The changes in the skin are often associated with the profound systemic effects of the drug, known as "Iodism," "Bromism." In these cases, in addition to the vascular pathological phenomena, there are nutritive or trophic modifications.

While there is no doubt that the vaso-motor nerves modify to some extent the nutrition of the tissues to which they are distributed, yet in these severer forms, characterized by a disturbance of local nutrition more or less profound, another agency than vaso-motor innervation is apparently involved—they are probably due to an impression of the drug upon the trophic centres which regulate nutrition.

Physiological research, as well as pathological facts, have demonstrated that the nervous system exercises a constant and controlling influence upon the nutrition of the tissues. Whether this influence is exerted through the nerves which regulate vascular supply, or whether there exist certain nerves with specialized functions which have been denominated trophic nerves, is immaterial to our present inquiry. The fact remains that a trophic influence is exerted upon the cutaneous tissues by the nerve-centres, and that when any impression disturbs this regulating power, perversions of nutrition result. This disturbing impression may be made upon the nerve-centres or upon the peripheral nerves. Peripheral irritations will cause reflex alterations of nutrition precisely as they cause reflex disturbances of motor functions.

The direct dependence of cutaneous lesions, varying in character and intensity from simple dermatitis to the profoundest changes in the skin and cellular tissue, upon alterations in the peripheral and central nerves, has been demonstrated by numerous anatomico-pathological investigations. The neuropathic origin of pemphigus, zoster, leprosy, symmetrical gangrene, decubitus acutus, mal perforans, ulcers of the leg, exfoliative dermatitis, and certain cases of eczema have been thus demonstrated. May we not reasonably infer a like pathogenesis in the case of drugs which are capable of exercising such a profound influence upon the nervous system?

The fact that structural alterations of the nerves, leading in many cases to abolition of their functions, have been found in the diseases just referred to, does not militate against this view. Physiological experiments have proven that molecular changes in the nerves, from excitations of transient influence, electricity for example, affect the nerve functions precisely as do gross pathological changes of structure, or even section of the nerve.

While there is no positive evidence that drugs produce modifications of molecular arrangement, however minute, in the nerve tissues, yet it is a noteworthy fact that a large proportion of the medicinal agents which

determine eruptive disturbances, act specifically upon the nervous system. Many drugs not credited with this physiological action undoubtedly exercise it. Proof of this proposition is found in the neuropathic character of the several groups of symptoms comprehended under the general terms, "iodism," "bromism," "cinchonism," "hydrargyrisms," etc., with which the irritant action of the drugs upon the cutaneous surface is so often associated. All authorities recognize these manifestations as due to a disorder of the central nervous system, caused by the depressant action of the drug upon the brain and spinal cord. If the impairment of sensation of mucous membranes, formications, muscular tremors, troubles of intelligence, parietic phenomena, and other grave symptoms of "bromism" be manifestation of the effects of the drug upon the nerve centres, why is not the concomitant "bromic acne," with which these symptoms stand in intimate connection, likewise a neurotic phenomenon? It is irrational to separate the skin affection from the group of other symptoms which make up this clinical picture, and assign to it an entirely different pathogenesis.

In concluding this study of the pathogenesis of drug eruptions, it may be said that the only correct interpretation of the physiological predisposition, known as idiosyncrasy, as a determining cause is based upon a recognition of their neurotic character. This conclusion may be derived from the presentation of the problem in the form of a syllogism, thus: Drug eruptions are determined by idiosyncrasies. Idiosyncrasies are neuroses; therefore, drug eruptions are neuroses.

Without considering possible objections to the validity of the premises, or the logical character of the deduction, we may safely assert that so far as we can apprehend the nature of idiosyncrasy, as affecting the cutaneous action of certain drugs, it seems to depend upon a heightened susceptibility of the nervous system, associated or not with a specific predisposition of the cutaneous tissues to irritant impressions. In persons who manifest this idiosyncratic intolerance, the equilibrium existing between the skin and the nervous system in their vascular and nutritive relations is easily disturbed, the form and intensity of the resulting reaction being largely determined by the physiological properties of the tissues affected.

As is well known, the incidental effects of drugs may be manifest in other organs. The explanation of their more frequent determination toward the skin must be sought for in the sympathetic lines which unite the nervous and cutaneous systems. The skin is not only the receptive surface of all sensory modifications from the external world, but it is the principal medium through which the nervous system manifests its emotional and other disturbances.

Proof of the neurotic character of drug eruptions may also be drawn from

the alterations of sensibility, with which they are associated ; their symmetry ; their generalization or their restriction to certain regions, according as the drug affects the general nervous system, or the special nerve centres which preside over particular cutaneous departments. Indeed, their very caprices and contradictions constitute a strong proof of their neurotic origin, suggesting a modification of the controlling, regulating influence exercised by the nerves upon circulation and nutrition.

PERI-URETHRAL ABSCESS. RUPTURE INTO THE URETHRA. COMPLETE CURE.

BY

JOHN WARREN, M.D.

THE following history is an interesting one, on account of the rapid closure of a urethral fistula, caused by a peri-urethral abscess complicating a case of gonorrhœa :

I was consulted on July 23, 1884, by a young man, 28 years of age, who gave the following history : Two weeks previously he contracted gonorrhœa, for which he did not at once seek medical advice, having had several previous attacks. He commenced the use of copaiba capsules as soon as he noticed the discharge. Several days before seeing me, he noticed a small lump on the penis, just behind the glans, on the right side, which gave no pain ; but as it increased in size daily he came to me to learn its cause. On examination, I found a swelling about the size of a pea on the forward end of the corpus cavernosum, one inch behind the corona glandis, on the right side, adjacent to the upper part of the urethra. It was hard to the feel ; little or no tenderness on pressure ; no fluctuation ; no surrounding induration.

There was a moderate discharge from the urethra, some ardor urinae, and his general condition was very poor. He was anæmic, and complained of having no appetite and losing flesh for the past week.

I diagnosed a peri-urethral abscess, put him upon tonic treatment, also an alkaline mixture. I saw him again in a day or two, at which time the abscess was a little larger, the gonorrhœal discharge about the same, but the general condition of the patient was better. I decided to make a free opening of the hard mass, which I did the next morning. On making a deep incision, a few drops of pus were evacuated, and on introducing a probe a small cavity was distinctly felt in close proximity to the urethral wall. A small tent of lint was introduced into the cavity,

and a poultice applied for twenty-four hours, during which time there was a free discharge. For several days after the opening remained well established, and continued to discharge. The tent was removed several times during the day, and a few drops of the balsam of Peru injected. Four days after the abscess was opened the patient had to leave town, during which time the external opening closed. Shortly after this he felt more pain than usual about the spot, also noticed some return of the swelling, and that the discharge from the urethra, which had been growing less, increased in quantity. A small probe was at this time with difficulty introduced into the sinus, but the opening was so small that it allowed no discharge to pass through it. The next day a small pustule made its appearance about one-third of an inch from the original opening, which ruptured immediately and discharged some pus.

I found, upon introducing a probe, a sinus which connected with the first one some distance from the surface, and upon injecting a few drops of balsam of Peru, it made its appearance in a few minutes at the meatus, together with a few drops of pus, showing that the abscess had ruptured into the urethra, probably at the time when he allowed the external opening to close. I established free drainage at once by converting the two sinuses into one, and thereby gave the abscess free external drainage and a chance to close by granulation, hoping that the urethral opening might close and avoid a troublesome fistula. The discharge through the external opening being re-established, that through the meatus diminished. The balsam of Peru no longer passed through the urethra upon being injected into the abscess, and there was every reason to believe that the urethral rupture had closed after free external drainage had been established. About this time another small swelling made its appearance just behind the "*frænum preputii*," on the same side as the first, rapidly followed by a third just beside it.

Dr. P. A. Morrow saw the case with me at this time, and advised incising them at once, which I did. From this time the patient improved, the gonorrhœal discharge gradually ceased, the incised wounds closed by granulation, his general condition continued to improve, so that by October 1st, the induration had been completely absorbed. There was a small stricture formed during cicatrization of the internal rupture of the urethral wall. A gleet remained, which disappeared after the passage of sounds.

Peri-urethral abscess with gonorrhœa is rare; it usually accompanies or results from stricture of the urethra. They are found at any point along the urethra, but usually near the *frænum*, beneath the fossa navicularis, or back near the bulb, at the peno-scrotal angle.

By some the seat of these abscesses are considered to be in the lacunæ, which rupture externally, leaving a fistulous opening; or they may

break into the urethra, but others think these abscesses begin in the connective tissue surrounding the urethra, as they do not impede the passage of the urine.

The rational symptoms, which vary with the size, number, and situation of the abscesses, are rigors, fever, loss of appetite, sometimes dysuria and severe constitutional disturbances. These abscesses are very apt to recur with succeeding attacks of urethritis, especially with decidedly acute cases, or where the patient has neglected himself or the treatment. We find that they rupture externally or internally; if the latter, infiltration and sloughing are apt to result.

A urinary fistula is more frequent near the bulb than at the glans; sometimes even when opened externally, we may have an internal rupture, as in the above case.

The treatment of this complication of gonorrhœa consists in free incision of the mass down to the urethral mucous membrane; this may be done before suppuration has occurred, or if in the perineum, we may wait for signs of pus. If the abscess occurs in the prostate, it usually opens into the urethra, or is opened during catheterism.

After the abscess has been opened and evacuated, free drainage should be maintained, and the abscess allowed to granulate from the bottom. If a fistula remain, it may, in rare instances, close, as was the case with my patient; if, as commonly occurs, the fistula refuses to close, surgical means must be resorted to.

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DERMATOLOGICAL NOTES.

BY

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New York.

I WOULD like to second the suggestion of Dr. Hardaway (in the April number of this JOURNAL) that the editors publish a series of "Dermatological Notes," by different writers. By so doing they would bring to the notice of the profession in a most concise form a large and valuable amount of instructive matter. Many therapeutic suggestions, clinical observations, and items of dermatological interest remain unpublished because they fail to make an "article" of conventional length. Or, on the other hand, they are sometimes published and the requisite length of the article obtained by a sacrifice of time and patience on the part of the reader.

Elephantiasis of Forearm and Hand.

In Waring's statistics of elephantiasis (quoted by Tilbury Fox) the disease affected the upper limb in but four cases among nine hundred and forty-five. This fact leads me to report briefly the only case of the kind which I have ever seen, and the only one, perhaps, which has ever been observed in this country.

Mrs. —, aged 46. A rather spare woman in average health. When quite a young girl, her left hand used to become red and swollen once or twice every year and resume its normal size and appearance. As she grew older, the attacks became more severe and were usually accompanied by a marked chill and fever. The swelling now would not entirely disappear as at the outset, and the hand and forearm gradually became enlarged. This condition has existed for at least twenty years. Twelve years ago, a palmar abscess formed, was lanced, and resulted in a slight flexure of the thumb upon the palm. Just before the attacks, which appeared to be of an erysipelatous character, the patient sometimes experienced a pain in the limb which extended above the elbow. Examination showed the skin of the left hand and forearm to be thick and firm in character, and somewhat dark in color from an imperfect circulation. The surface was dry, harsh, and slightly scaly. There was no sensation of pain or itching, and the patient could use the hand readily, although it was somewhat stiff and awkward. The comparative size of the upper extremities is shown by the following measurements taken at the wrist,

middle of forearm, hand, and index finger: *Right*, 6, $7\frac{1}{2}$, $7\frac{1}{4}$, $2\frac{1}{2}$. *Left*, $7\frac{1}{2}$, $8\frac{1}{2}$, 8, 3.

A decided improvement, according to the patient, followed the daily inunction of the oleate of mercury (5%). In the morning the hand would be quite limber, but the pressure of blood would soon cause it to become stiffer and dusker in hue.

Zoster Occurring in Pregnant Mother and later in Child.

A male child of five months was recently brought to the Skin and Cancer Hospital with a well-marked zoster of the right upper extremity. The patches extended from the sternum and scapular region along the inner surface of arm and front of forearm, over the palm and to the tip of the middle finger. Small vesicular patches were also noted on the posterior surface of both middle and ring fingers. The mother of the child stated that at about the fourth month of pregnancy she had a patch of similar eruption upon her right thigh, and that with a previous pregnancy she also had the eruption at nearly the same point and at about the fourth month. She seemed positive that the eruption which had appeared upon her thigh was exactly the same as that upon her child, stating that the patch on each occasion was red and "covered with groups of yellowish heads," and that it disappeared in two or three weeks without treatment. The former child has never had zoster.

I believe this is the youngest patient in which I have ever observed the disease. As to any relationship between the eruptions of mother and child, I will leave the reader to draw his own conclusions.

Inherited Keratosis of Palms and Soles.

A callous condition of the palms and soles, independent of external causes, is somewhat rare. Recently I have had several members of a family under my care, whose cases have illustrated the inherited tendency to this condition. Mr. J. came to me with a thickened yellowish horny appearance of the palms which had existed since infancy and which he had only kept from getting worse by the daily use of pumice-stone. In the natural creases of the palms and soles the epidermis was thinner and slightly powdery. Elsewhere the skin was normal. He perspired very freely even where the epidermis was thickened. According to his statement, which I had the opportunity later of partially verifying, his mother, and maternal grandfather, an uncle, a brother, two sisters, and two little nephews, were all similarly affected. His mother had eight children, and it was a noteworthy fact that every second one inherited this dermal peculiarity.

Another patient with a somewhat similar condition of the palms and soles presented a well-marked keratosis pilaris of arms and thighs and a

general ichthyosis of a mild type. His father was also affected with keratosis of palms and soles. It will be noted that this patient exhibited on his own person three peculiarities of epidermic growth, which are intimately related in their pathological aspects, but which are commonly described in the text-books as distinct diseases.

The Best Method of Removing Comedos.

Numerous little instruments have been devised and used by both physicians and patients for the extraction or rather the expression of comedos. Most of them seem poorly adapted to the purpose. For many years I used a silver tube, with a carefully rounded extremity, which certainly possesses advantages over the watch-key so frequently employed by patients and the various comedo-extractors sold by instrument makers. I am now convinced that a small, narrow, and deep curette (modelled after the hull of a canal-boat) is the best instrument that can be employed for pressing out the sebaceous plugs. The use and the value of the curette as a scraper in cases of acne and comedo is well known, but its use for the purpose of pressing out the comedos, with the least injury to the skin, I believe to be novel. Whoever acquires the "knaek" which is necessary for its successful employment will not care to use anything else. When used, the beak of the curette should be gently pressed upon the skin at one side of the comedo, the handle being almost at a right angle with the cutaneous surface. Now, by a sudden and *quick* revolution of the handle between the thumb and forefinger, the result is accomplished. A slight pressure has been exerted successively on all sides of the comedo, and the white cheesy worm is usually found lying in the hollow, rounded end of the curette. A convenient vest-pocket instrument for use in cases of acne has been made for me by several instrument makers of this city. It consists of a tubular handle to the ends of which are screwed a curette such as I have described and an ordinary acne lancet. When not in use, the instruments are reversed and screwed within the handle.

The Iridio-platinum Needle in Electrolysis of the Hair Papilla.

In the "Dermatological Notes" of the April number of this JOURNAL, Dr. Hardaway states that he has been easting about for many years for some needle that would effectually meet the requirements of the operation for the removal of superfluous hair. The needle composed of iridium and platinum of which he now speaks highly is by no means a novelty in New York. It was first used by Dr. Piffard about ten years ago, and mentioned by him in his book ("Diseases of the Skin," 1876, p. 307).

My own preference is for a fine *flexible* steel-needle, such as can be

obtained of various sizes and at an almost nominal cost from any wholesale dealer in jeweler's supplies. The fact that I have employed such a needle in the treatment of more than a hundred cases of facial hairiness, in some cases removing several thousand hairs, is the best recommendation I can give it. In fact, I would not wish for anything better.

A Rat-Bite of the Penis.

A few years ago, Mr. —, a married gentleman, living out of town, was engaged in business in the lower part of this city. One day, upon returning from his lunch, a call of nature led him to seek the seclusion granted by the subterranean apartment of his mercantile building. The privy, here in use, was of rather primitive construction, being connected with the sewer-pipe without the intervention of a basin, and rats had frequently indicated their presence in the walls of the premises. While Mr. — was sitting and quietly enjoying that contemplative mood which naturally steals over one in this form of post-prandial siesta, he was suddenly startled and forced to bounce from his seat in a manner most hasty and undignified. Blood was dripping on his pants from a fresh wound of the penis. It required a full moment to take in the situation when, with a suspicion that he had been bitten by a rat and a confused notion of possible results, he rushed for medical aid.

When I examined him shortly after the occurrence, I found on the left side of the sheath of the penis a loss of substance three-fourths of an inch in length which had evidently been produced by incisor teeth or some other sharp, cutting instrument. The wound, still bleeding, was cauterized with fused nitrate of silver, and the fears of the patient were gradually allayed. The wound healed quickly, leaving a superficial scar. In a note received a few weeks later, the patient remarked that, although a rat-bite might not be dangerous, the inconvenience of its presence on such a portion of the body could not be overestimated.

There is a moral to this story. A week after the bite occurred, the wound looked very much like an ordinary chancre. Now what would the reader say if a respectable married man were to come to him with an apparent chancre of the sheath of the penis and state that he had had no illicit intercourse, but had been bitten by a rat?

This story teaches that the physician who disbelieves in the vicious nature of the water-closet in connection with venereal disease might, in an exceptional case, be unwarrantably incredulous.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

153D REGULAR MEETING, MARCH 24, 1885.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. FOX presented two cases of

SYPHILIS MODIFIED BY ECZEMA.

The first patient, a German, about 50 years old, has had syphilis extending over a period of twenty-eight years. His wife has had five miscarriages. The eruption on the hands and fingers first made its appearance twenty-five years ago. When first seen by Dr. Fox the patient had a well-marked verrucous eczema of the hands, the moist discharge proving that the lesion had some of the elements of that disease.

Now he has an eruption on the wrists, hands, and fingers, the lesion presenting the appearances of a characteristic syphilide made up of discoid patches, which have a tendency to run together. These patches heal in the centre, and spread at the edges. They have well defined margins. On the hands and fingers are several such orbicular patches, tubercular in character. The nails of the right hand are discolored, very thick and brittle. Dr. Fox, when he first saw the case, believed it to be an eczema engrafted on a syphilide. He first gave acetate of potash internally, and soothing ointments were applied for several weeks with only slight benefit. When the mixed treatment was given and ammoniated mercury ointment applied, the patches healed in the centre, leaving a well-defined ring of diseased tissue around them. He remained away for six weeks, without treatment, when the eruption reappeared. Lately he has been treated locally by means of rubber gloves and a solution of salicylic acid in castor oil.

The second patient has had the eruption over a year. She has a chronic infiltrated eczema extending over the knuckles as well as the back and sides of the hands. The eruption also exists on other parts of the body. The lesion on the back of the hands presents an orbicular, scalloped margin, which to him (Dr. Fox) was an indication that the disease was modified by syphilis. He had always been of the opinion that syphilis did not modify other skin affections, but in view of the cases just presented and others that he had seen of late, he had changed his views on the subject. The patient was now taking acetate of potash with colchicum, and as yet there had been but slight improvement.

DR. KEYES thought that the first case presented evidences of a syphilitic nature in the isolated patches on the arms and the circinate spots on the hands. It also had an eczematous appearance. The scalloped and irregular edges that Dr. Fox drew attention to had often been observed by him in cases of gouty eczema. It certainly was an eczema implanted on a syphilide.

He considered the second case an eczema and did not see any evidences of syphilis present.

DR. MORROW said that he agreed with Dr. Keyes in his views as to the nature of the lesions present in the two cases. He would take exception to the remarks made by Dr. Fox that the treatment employed would determine the nature of the disease: viz., if the lesion disappeared or even improved under the mixed treatment that it was necessarily a syphilide. He remembered having shown two cases to the Society some few years ago, for diagnosis between eczema and

syphilis. He said that it was curious to note the change in opinion from one meeting to another as to the nature of the lesions. The patient was put on a treatment for eczema without producing any marked effect, afterward to test its syphilitic nature mixed treatment was employed and mercurial plaster applied with the result of aggravating the symptoms. He had seen many cases of frank eczema that presented appearances similar to those seen in the lesion affecting the first patient. He did not think that the treatment test would always positively determine the diagnosis in cases of suspected syphilis.

DR. SHERWELL was inclined to agree with Dr. Fox in regard to the diagnosis, etiology, and basis of treatment employed in the first case. He believes that syphilis modifies eczema.

He considered the second case to be one of eczema.

DR. JACKSON said that when he saw the first patient at the clinic for the first time, the lesion presented all the appearances of a verrucous eczema, but when he saw him at a later period he had no hesitation in diagnosing it as syphilis.

The second case had many of the characters of syphilis, especially the orbicular margin on the back of the hands.

DR. BRONSON thought there was no doubt but that an eczema and syphilis could be in juxtaposition, especially in a person with an eczematous diathesis. There must, however, be positive evidence of syphilis, which did not exist in these cases, although there was a well-defined border to the patches. In these cases, however, we do not find a multiplicity of lesions, an irregular distribution, or an infiltration at the margins of the lesions, all of which are present to a greater or lesser degree in syphilis. He would not call these cases syphilides. We often meet with cases of eczema with orbicular edges occurring in patients who have an arthritic diathesis.

DR. ROBINSON said that in his experience there was no reason to believe that syphilis at any time altered or modified an eczema. Syphilis always spreads toward the periphery, but he could not understand why a catarrhal inflammation of the skin, such as an eczema, should spread in that way simply because the person had syphilis. He would agree with Drs. Keyes and Morrow that it was almost impossible to make a diagnosis between eczema and syphilis.

In the second case, he failed to see any evidence of syphilis. There is nothing uncommon in the scalloped border that the eruption presents; it is often seen in rheumatic or gouty patients.

DR. KEYES said that whether syphilis modified an eczema or not, it was a well-known fact that often when fractures do not show signs of uniting, if the patient be put on an anti-syphilitic treatment, the bone unites, although there may be no evidence of syphilis. He believed that patients with eczema, especially those whose health had run down, often improve under the mixed treatment. He does not know how it acts, whether there is something in the diathesis of the patient, or simply because of the tonic effect of the medicine.

DR. PIFFARD believed that when a person spoke of a syphilitic taint without stating whether the disease were syphilis or not, that it was the resource of ignorance; either a patient has, or has not, syphilis. He had seen eczema, psoriasis, and lupus in persons affected with syphilis, but had never seen syphilis modify any other eruption. He cited a notable instance of a man who had an ulcer of the ankle, the result of an accident; he (Dr. Piffard) treated it with balsam without any benefit until he discovered a chancre in the process of healing. Here, then, was an ulcer occurring after acquiring syphilis, but before the appearance of the secondary manifestations of the latter disease. The patient was placed on anti-syphilitic treatment, and the ulcer immediately healed.

DR. FOX, in concluding the remarks, wished to say that for some years he had taught and argued that syphilis never modified any disease of the skin, but in the last year or so he had met with and studied a series of cases such as those now under consideration, and had reason to change his mind. He agreed with Dr. Robinson that it was difficult to make a diagnosis from the configuration of the lesion, but there was something in the appearance of the skin that he could not describe which led him to form a conclusion. With regard to making a diagnosis from the treatment employed, he, in the main, agreed with Dr. Morrow; but in the case where the eczema treatment failed to produce any beneficial results, and afterward when the mixed treatment was employed the lesion suddenly disappeared, he thought he was justified in believing it to be syphilis. If there

had simply been an improvement, he would not consider it an indication that syphilis was present.

DR. FOX then showed a case of

DERMATITIS HERPETIFORMIS.

The patient has had the present eruption for the past six years. When seen for the first time a few weeks ago, the patient had a number of vesicles on the side of the face. She has had the eruption all over the body. The lesion is slightly pruriginous, and is what some would call a pruriginous pemphigus.

DR. ROBINSON presented a case of

LUPUS ERYTHEMATOSUS.

Mrs. L., 45 years old, had small-pox when a child, but no lesion of the skin, with that exception, until four years ago. At that time she had an eruption which commenced on the right ala of the nose, and spread on both sides of the face, and for a short distance on the shoulders. It remained about nine months, itched slightly, was unaccompanied by a discharge, and left no scars. Two years ago the lesion returned, commencing on the forehead and extending down the side of the nose to the cheeks, involving the jaws and ears. The eruption is the same on both sides of the face; it has been on the forearms about two months. On the left side the patches vary in size from a pin-head to several inches in diameter. They are red, somewhat elevated, sharply defined, and covered with a few firmly adherent scales. There are no signs of exudation on the free surface. One of the patches is slightly elevated toward the margin, but more depressed in the centre, and is covered by a few flat, thin, firmly adherent scales. The ear is somewhat thickened, there are no fissures. No atrophy over the site of the former eruption. In some places the patches are even depressed at the margins. On the forearms there are from fifteen to twenty spots from the size of a pin-head to that of a bean; there is one irregular patch five or six times larger than the others. There are no acuminate papules. The peculiar feature of this case is the absence of scarring over the site of the former eruption.

DR. BRONSON exhibited a case of

SEVERE PRURITUS.

The patient, a woman, 21 years old, has had the present eruption for over ten years, being worse in winter than at any other season. Now all the body, arms and legs included, is covered with a very fine papular eruption. It first made its appearance as an urticaria, there being also a certain amount of eczema present. This lesion differs from the true prurigo of Hebra, in attacking the upper rather than the lower extremities. He believed, however, that it was closely allied to that disease. Sugar was found to be present in the urine. Internal treatment had been of no avail. Locally, a solution containing two drachms of carbolic acid to one ounce of glycerin and water had been applied, and the parts afterward dusted with powder.

DR. CAMPBELL then showed a case of

PIGMENTATION OF THE SKIN CAUSED BY THROMBOSIS OF THE VEINS OF THE LEGS.

J. O., 39 years old, German, and by occupation a sailor, seven years ago first noticed a red lump under the skin of the calf of the right leg; this ulcerated and left a scar. Since that time other small nodules have made their appearance always over the valves of the veins, but have not ulcerated; after their disappearance a yellowish-brown stain is left. When these lumps first make their

appearance they are very painful. The veins of both legs are slightly enlarged. Now both legs from the knee downward are covered with these pigmented patches, and new lumps are continually forming. The patient has never had syphilis or gonorrhœa.

DR. FOX then made some remarks on

BALSAM OF PERU COMBINED WITH VARIOUS METALLIC OXIDES AS AN ADHESIVE DRESSING FOR MANY LESIONS OF THE SKIN.

He said that he had lately been experimenting with certain applications for the purpose of obtaining a new form of adhesive dressing. The one that he had used chiefly was a preparation containing one part of precipitated oxide of zinc to three of balsam of Peru, which he had found the least stimulating of all the balsams. It formed a very soft ointment, was readily applied to the skin and easily hardened, thus completely protecting the parts. Ether and chloroform were added to some of the preparations, but they were too stimulating, as was balsam of fir, although Dr. Jackson informed him that in one case under his observation the latter balsam was milder. He (Dr. Fox) has applied this preparation over moist and exuding surfaces even in children without producing any more pain than an ordinary ointment. The objection to the use of an ointment was that it became dry, and was then friable. He had tried adding oil to the preparation, but found that it was too liquid. When the parts become dry and there is a tendency to fissuring, the surface could be made smoother and the cracks filled up by applications of oil. He had obtained the most gratifying results from the use of these preparations. The various metallic oxides, such as zinc, bismuth, magnesia, etc., could be employed in combination with the balsam of Peru. He had prescribed the balsam and oxide of zinc separately and had them mixed afterward. The effect of these preparations was to relieve the congestion of the skin, and it was accomplished more quickly than by the application of the ordinary oxide of zinc ointment.

In connection with this subject, DR. BRONSON showed a case of

ECZEMA BARBÆ.

A man, 25 years old, has an eruption covering the chin and upper and lower lips, also extending down on the neck. There is a slight amount of infiltration of the skin. A ten-per-cent solution of pyrogallie acid was used for a week without much benefit. Now, oxide of zinc one part and three parts of balsam of fir, with sufficient ether to make the preparation soft enough, was employed.

Dr. Bronson said, in reference to the preparation applied in the case just shown, that when the ether is added too quickly it separates, but that it can readily be mixed again. Where there are excoriated places the application of the preparation produces smarting, but he would not consider this a serious objection, as it did not inflame or congest the parts. Ether was less irritating than chloroform.

DR. MORROW said that there was, undoubtedly, a great future for fixed adhesive dressings in the treatment of many forms of skin affections. He thought that Dr. Fox's new preparations were commendable, but he failed to see their superiority over the gelatin and glycerin combinations. The latter were more or less elastic and were bland and more readily adherent. He used salicylic acid and alcohol to remove the scaling in psoriasis and then applied the medicated gelatin. He noticed in the case shown by Dr. Bronson that the dressing was cracked and fissured in many places, probably due to the extreme mobility of the

parts on which it was applied. He had never seen fissuring result from the use of gelatin preparations; the addition of ether caused irritation. He had of late used compound tincture of benzoin, from which the alcohol is evaporated, leaving a solid residue which is redissolved in collodion. This preparation was protective and healing. He had applied it every day for several weeks to a rodent ulcer involving the cheek and side of the nose, occupying a space about twice the size of a silver dollar. The surface was so sensitive that it bled very easily. He had used various preparations, but found that this was the best. It was applied by means of a camel's-hair brush, causing little irritation and forming a protective coating which was generally left in place from twenty-four to seventy-two hours.

DR. FOX said that he had used oxide of zinc and iodoform, in combination with balsam of Peru, in the treatment of ulcers occurring in dispensary practice. He had never been able to get a perfectly smooth and even surface with gelatin preparations.

DR. FOX showed two cases of

PSORIASIS TREATED WITH SALICYLIC ACID IN CASTOR OIL.

The first patient, a girl 8 years old, who has a psoriasis covering all the body. The patient's father and sister also have psoriasis. When she was admitted to the hospital, a two-per-cent solution of salicylic acid in castor oil was applied to the right arm, a weak solution being used because of the great congestion of the skin. The scaling is less, and many of the patches have disappeared, although the disease is extending in other directions. To the left arm the mixture of oxide of zinc and balsam of Peru has been applied, and there is even less congestion in this situation.

In the second case, the lower extremities are chiefly affected. This patient is peculiarly susceptible to action of ammoniated mercurial ointment, even a very small quantity exciting the severe dermatitis. Chrysarobin pigment has been applied to the right leg, and a five-per-cent solution of salicylic acid to the left leg, producing a marked improvement in the condition of the eruption in the latter situation.

DR. MORROW said that he had for a long time used a two to four-per-cent solution of salicylic acid in cosmoline in pityriasis, in scaly eczema, and for removing the scales of psoriasis, preliminary to a more active treatment. He was glad to know that castor oil proved so admirable a solvent. In many cases he believed that psoriasis would improve under an indifferent treatment. In some cases he had treated one side of the body with linseed oil, and the other with pyrogallie or chrysophanic acids, without any marked difference in the relative rate of improvement of either side. Of late, he had found that chrysarobin did not produce the irritative effects that he had formerly observed from its use.

DR. PIFFARD found that ten per cent of salicylic acid would not dissolve in oil, unless oil of lavender were used. He used oil of lavender and oil of eucalyptus, each half an ounce, and castor oil an ounce, as a solvent. Salicylic acid dissolved in liquor guttae perchaë possessed an advantage over a collodion solution, because in the former the salicylic acid rises to the top and can easily be shaken up, while in the latter it sinks to the bottom.

DR. FOX said that there was an advantage in using the preparation made with the oil, because it was not irritating. He was pleased to hear the suggestions made by Drs. Morrow and Piffard, and remarked that ordinary oils do not dissolve salicylic acid so readily as castor oil.

ADULTERATION OF DRUGS.

DR. PIFFARD asked the members present, what their recent experience had been in the use of white precipitate ointment. He was in the habit of using it, in its full strength, without producing dermatitis; but of late he had two cases where there was an intense inflammation set up.

DR. BRONSON said he recalled two cases in which pustulation was caused

by the application of an ointment containing fifteen grains of the white precipitate to the ounce.

DR. MORROW thought that we should always be on the look-out for incidental and unusual effects from drugs, whether using them locally or internally. He had seen dermatitis result from the use of almost every form of ointment. Oleate of bismuth or even oxide of zinc ointment sometimes produce irritant effects. This he thought depended less upon the impurity of the drug than the susceptibility of the patient's skin.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

(From our Special Correspondent.)

GENITAL DIABETIDES—CHROMIDROSIS—HERPETIC ANGINA AND ZONA OF THE PHARYNX—INFANTILE CRUSTS—ECZEMA—GENERALIZED EXFOLIATIVE DERMATITIS IN A SYPHILITIC—FRACTURES IN SYPHILITICS—PRECOCIOUS AND LATE OSSEOUS LESIONS IN HEREDITARY SYPHILIS—LESIONS OF THE LIVER IN LATE HEREDITARY SYPHILIS.

Genital Diabetides.—In causing to be published by our excellent colleague and friend Dr. Barthélemy his remarkable lectures upon Genital Diabetides, Prof. Fournier has popularized an eminently useful work, directing the particular attention of practitioners to the investigation of the primary cause of a cutaneous affection to which they attach too slight an importance; in addition he has presented the clearest, the most complete, and the most classic monograph in existence upon these accidents. Genital diabetides differ from other diabetides in that they depend upon two causes—the one, a general cause, which is the influence exerted by the glycemia upon the entire surface of the skin; the other a local, topical cause, which is the contact of the saccharine urine with the integuments of the genital organs. Saccharine urine rapidly undergoes an acetic or lactic fermentation which cannot be otherwise than very irritating, and it produces upon the cutaneous surface a parasitic cryptogamic vegetation discovered by Frederich, forming a slight, superficial, follicular, white coating upon the glando-preputial surface, or upon the internal surface of the labia minora, etc. . . . According to Balzer, it is histologically constituted by a mass quite similar to that of the *oidium albicans* and is composed: 1st, of spores isolated or grouped, rounded, oval, or elliptic, consisting of an envelope and a nucleus; 2d, of long tubular filaments, articulated, some ramified, others terminating in an enlarged extremity, some containing a variable number of spores, others empty and withered. The genital diabetides are always preceded by a genital pruritus more or less intense, but which sometimes assumes, especially in women, a violence altogether exceptional, and which may exist, at its debut, without the slightest apparent dermatosis, and even without the patient exhibiting any of the peculiar symptoms common to diabetes, polyphagia, polydipsia, polyuria, debility, hebetude, etc. It is, therefore, always necessary in the presence of a case of genital pruritus to examine the urine.

From an objective point of view the genital diabetides, in the case of women, present themselves under the form of a vulvar erythema, more or less general, then a vulvar eczema, sometimes taking on an acute form, with intense redness, tumefaction of the parts, serous exudation, general painfulness. Sometimes in the chronic form, with thickening and even hyperplastic tumefaction of the affected tissues; the labia majora are massive, swollen, but without true oedema; the labia minora are distended, elongated, and peudulous; the vaginal orifice and likewise the anterior portion of the vagina present an intense redness and pronounced tumescence of the mucous membrane, and here and there, *au niveau* the vulva and the vaginal orifice, are observed white follicular coatings which are due to the parasites. The principal characteristic of this diabetic eczema, is its obstinacy to local treatment, which only ameliorates the symptoms, its continual tendency to recurrences, and to fresh crops, as soon as the topical applications are neglected. Most often it disappears only with the glycosuria; still with much care and time, it may be subdued by employing temperate baths (of bran or starch) frequently repeated, lotions of the bicarbonate of soda or borax, vaginal injections containing thirty grams of boric acid to the pint, methodic sprinklings of powder in the cutaneous folds, etc.

In the male are also observed erythemas and eczemas; the most common form of genital diabetides consists of an erythematous balanitis, characterized by a simple intense redness of the glans. In a more advanced stage, there are found upon this reddened surface small excoriations, quite superficial, with a purplish, red base, rounded or irregularly oval in form, never preceded by vesicles; this is the balanitis herpetiformis. A third type is constituted by eczematous balanitis and balano-posthitis; most often it is a dry and desquamative eczema of the glans, which is of a color sometimes red, sometimes a dark-red, with an epithelium thick, cracked, broken, scaly, with here and there linear fissures, terminating in little furrows, some erosive, some bleeding, others covered with a crust. The same appearance is presented by the internal surface of the prepuce, which is slightly oedematous, and the extremity somewhat reddened. This balano-posthitis has an aspect and a localization so special that it should at once suggest diabetes. When neglected, it may gradually develop into diabetic phimosis by the progressive thickening of the prepuce, diminution and loss of elasticity of the organ, gradual narrowing, then complete atresia of the preputial orifice. Then the phimosis reacts unfavorably upon the balano-posthitis, of which it was the consequence, rendering it much more intense by causing prolonged contact of the urine with the diseased surfaces.

Dr. Martin has called attention to the incessant reproduction, in certain cases, of glandular vegetations in diabetics. In order to prevent these accidents, it is necessary, first of all, to treat the diabetes, then recommend the patient to always uncover the glans in urinating, and to wash, or at least carefully dry, the glans and prepuce after each micturition.

When genital diabetides are already developed in the male, they can be most successfully treated by the employment of the means before indicated for the same condition in women, viz., local and general baths, alkaline lotions, absorbent powders; it is quite possible to cure the phimosis without operation by frequently repeated injections of alkaline solutions, and, if there be acute inflammation with suppuration, a solution of nitrate of silver ($\frac{1}{100}$ to $\frac{1}{200}$). As soon as the glans can be uncovered, the contiguous surfaces should be isolated with an inert powder and dressings of lint. Prof. Fournier, in terminating his study of this subject, calls attention to the fact that there also exist gangrenous diabetides

of the genital organs; an accident exceedingly rare, but a case of which he had observed in his own practice.

Chromidrosis.—Since the last researches upon chromidrosis, to which I referred in one of my previous letters, the attention of clinicians has been directed to this particular point, and many cases of this curious affection have been published. At the meeting of the Paris Academy of Medicine, Dec. 2, 1884, M. Lison related the cases of three patients, all males, who were attacked with yellow chromidrosis of the neck. They presented no symptom of icterus, no coloration of the conjunctiva and skin, no characteristic reaction of the urine or other secretions, no morbid phenomena which would lead one to suspect an affection of the liver. The chromidrosis disappeared completely in these cases in the course of two or three months, without other treatment than occasional purgatives and alkaline drinks. The author declares that he was unable, notwithstanding the most careful investigation, to discover the nature and the cause of this singular infirmity.

Herpetic Angina and Zona of the Pharynx.—In an interesting communication made to the Congress of Blois, in 1884, Dr. Ollivier exposed his new researches upon the pathogeny of herpetic angina. From numerous cases cited by him it appears that herpetic angina may coincide with certain rheumatic manifestations and with a herpetic eruption characteristic of zona developed along the course of a nerve. The author has seen a herpetic eruption of the throat accompanied with a development of herpetic vesicles upon the internal surface of the cheeks and the lips, upon the anterior third of the tongue, the nasal fossæ, the conjunctivæ, upon the cutaneous surface of the forehead, the eyelids, the nose, and the lips—all regions innervated by the trifacial. The precise seat of the eruption, upon the territory of this nerve, and even upon the territory of certain branches of the fifth pair, the *ensemble* of morbid phenomena, the neuralgic pains, the swelling, the sensations of heat and burning, the cyclic evolution, seem to conclusively prove that there was in these cases a sort of storm in the sphere of the trifacial, and strongly point to the probability of the nervous origin of herpetic angina, which would then be a veritable zona. The author has even seen herpetic angina coincide with a zona of the suboccipital nerve. He does not hesitate then to affirm that certain herpetic anginas ought to be completely assimilated to ophthalmic zona and regarded as zonas of the pharynx. As to the etiology of these anginas, Dr. Ollivier believes with Drs. Verneuil and Leudet that they should be recognized as due, like other zonas, to multiple causes of diverse nature, but that for the most part they develop as the result of cold, especially when the patients are in a condition of systemic depression. It would be curious to ascertain whether these anginas ever recur, as it is well known that one of the distinctive characteristics of true zona is that it almost never recurs.

Infantile Crusts.—Dr. Descroizelles, physician to the *Hôpital des Enfants Malades à Paris*, has in one of his recent clinics studied this eruption. He shows that the *gourme* formerly served to designate almost all infantile eruptions, but at present it is restricted to those eruptions which have for their point of departure an eczema or an impetigo, and which are characterized at a period more or less advanced from their début by an abundant liquid exudation, then by crusts of variable thickness and aspect, accompanied by itching. These eruptions correspond well to the benign exudative scrofulides of Bazin in young children. After a study of cases of the cutaneous affections generative of crusts in infants, eczema and impetigo, the author remarks that these two dermatoses, after having passed through many phases, finish by forming quite extensive crusts, sometimes

whitish, or of a clear gray, nearly dry, and quite adherent, sometimes brownish, greenish or blackish, soaked with pus or blood, and easily detachable. The term *gourme* should be reserved for these concretions. The seat of predilection is the head, but it may also be found on other regions of the body. It is sometimes difficult to determine the cutaneous affection which originated them, whether an eczema or an impetigo, a matter of some importance from a prognostic point of view, impetigo being more rapid in its evolution than eczema, and also being inoculable. Impetigo gives rise to crusts softer, more yellowish, thicker, less adherent than those of eczema. To the eruptions which seem to partake at the same time of the characteristics of both eczema and impetigo, French authors have given the name of impetiginous eczemas. These are the cases which have led certain authors to regard them purely and simply as an impetiginous variety of eczema. This is an error of observation. One should not confound crusts with the parasitic affections of the hairy scalp, in particular with favus and trichophytosis, which may simulate them. It is also necessary in all doubtful cases to make a histological examination of the hairs and crusts.

That which is popularly called *la chapeau*, should not be confounded with these crusts, for it is only a simple product of the secretion of greasy matter, which is often found in the scalp of certain children, who have not been subjected to the proper use of soap. Thus understood, infantile crusts cannot have an unfavorable prognosis, they never leave cicatrices, but they may recur, or persist for a long time. They often have close connections with the lymphatic temperament, but they may also be observed in robust and well-developed children. The presence of certain parasites, especially pediculi, is quite often an active cause.

Contrary to the teachings of the Vienna school, M. Descroizelles does not treat as chimerical the fears of the older authorities who thought that a too rapid cure might coincide with grave visceral accidents. He thinks that we ought to carefully observe children in this regard, and always respect the dermatoses when we perceive that general disorders are produced as soon as the cutaneous secretions diminish.

If the eruption is very extensive it should be gradually cured, treating successively the various regions involved. The best methods of treatment consist in softening the crusts with olive oil or almond oil, then covering the diseased parts with impermeable dressings, such as caoutchouc or vulcanized cloth, and washing in water of walnut leaves two or three times a day. To facilitate this swaddling, bonnets, masks, gloves, stockings, etc., of rubber, are employed, as in eczema. When the crusts are removed, and the surfaces are not much inflamed, the cure may be hastened by applications of ointments of vaseline, medicated with either goudron, tannin, or calomel, ($\frac{1}{2}$ ss, $\frac{1}{3}$ ss or $\frac{1}{4}$ ss), according to the susceptibility of the patient. It may sometimes be necessary to have recourse to the oil of cade or to sulphur lotions. Where there is intense itching, emollients or feeble astringents may be employed, such as starch poultices, almond powder, sub-nitrate of bismuth, oxide of zinc, bran water, etc. Finally, M. Descroizelles regards it important to attend to the general condition of the patients, to give them iodide of iron, cod-liver oil, sulphurous and arsenical preparations.

We may remark, however, that the term, crusts, indicates only a particular aspect which eruptions of diverse nature may take on, and that in reality it does not respond to any well-defined malady, nor does it have, it seems to us, any scientific value.

Eczema.—I would call the attention of American dermatologists to an excellent

monograph upon eczema which has just been published by Dr. Deligny, Paris, 1885. They will find in it nothing peculiar to the author, but an excellent resumé and careful exposition of the ideas, the theories, and the therapeutic methods which are held in highest repute at the present time.

Generalized Exfoliative Dermatitis in a Syphilitic.—M. Poupon has just communicated to the Clinical Society of Paris the very interesting case of a woman 39 years of age who had syphilis in 1882, and who, in July, 1884, had a double iritis with synechiæ and a perforation of the vault of the palate, for which she had been ordered mercurial pills, with two grams of iodide of potassium a day. The syphilitic accidents amended rapidly under the influence of the treatment, but, on the 15th of August, the patient observed upon her arms a redness, which rapidly extended to the trunk, and then became generalized over the entire surface of the body. The skin was red, tender, swollen, pruriginous. At the end of eight days the red eruption commenced to desquamate; this desquamation began on the arms and soon became generalized over the entire cutaneous surface. During the latter part of August, the entire month of September, and the earlier part of October, the redness and the lamellar desquamation continued in large imbricated scales upon the trunk, and in small scales upon the face. All the hairs of the head fell out in the early stage of the eruption, the greater part of the hair of the pubis, the axillæ, the eyelashes and the eyebrows likewise fell out. The nails were much altered. The patient, quite emaciated, had a succession of febrile attacks. It was impossible not to recognize this as a case of a disease examples of which are found scattered here and there in the publications of various authors, and which, three years ago, I described under the name of generalized exfoliative dermatitis, or malady of Erasmus Wilson. In America, England, and Germany, it has been confounded with a different affection termed pityriasis rubra. I may add that the patient entirely recovered.

Fractures in Syphilitics—Precocious and Late Osseous Lesions in Hereditary Syphilis.—Since the brilliant lectures of Prof. Fournier attracted the attention of French physicians to hereditary syphilis—a subject hitherto but little studied among us—publications bearing upon this subject abound in our country. In his excellent thesis upon “Fractures in Syphilis” Dr. Gellé has remarked that we may observe in syphilitic children two classes of osseous lesions: epiphyseal detachments and fractures, either near the epiphyses, or in the middle of the diaphysis, lesions which give rise to pseudo-paralyses. Dr. Borne has taken up this question, and has recently given us a most conscientious and complete exposition of all the modern researches upon all the osseous lesions, early and late, of hereditary syphilis (Paris, 1884, 110 pp.). I am obliged to refer your readers to this work, as it would require several pages to give even a resumé of the labors of Parrot, Lannelongue, Fournier, and of the author, which are here found condensed.

Lesions of the Liver in Late Hereditary Syphilis.—I will mention, in closing, the excellent memoir of my friend Dr. Barthélemy upon the lesions of the liver in late hereditary syphilis. He shows from 32 cases, many of which have not been published, that late hereditary syphilis determines four varieties of lesions of the liver: 1st. Lesions of an apparently purely congestive nature, characterized by a slight sensibility and augmentation of the volume of the liver—by a subicteric tint of the integument—by dyspeptic and rebellious gastro-intestinal disorders—accidents which rapidly disappear under the influence of iodide of potassium. 2d. More profound lesions determining a diffuse interstitial hepatitis—a cirrhosis rather hypertrophic than atrophic; this form of late hereditary syphilis

is frequent; in the earlier stages it may be cured by a methodic treatment, but neglected it kills the patient sooner or later. Sometimes the lesions present the mixed characters of sclerosis associated with gumma; it then constitutes the sclero-gummosus form, the course of which is quite variable in different cases. 3d. Lesions tending to the production of gumma in the hepatic tissues, gumma which in healing causes corrugated cicatrices so characteristically seen in the furrowing of the surface of certain livers. 4th. Finally, lesions exceedingly grave, accompanied by amyloid degeneration of the gland, the amyloid variety; another mixed form, the amylo-gummosus, is also sometimes observed. There is not, according to Dr. Barthélemy, any notable difference, from an anatomical point of view, between the hepatic lesions due to acquired syphilis and those due to hereditary syphilis; but the clinical picture is different in the sense that the infant or the young adult hereditarily infected, present the characteristic facies of the diathesis—characteristics so well studied by Prof. Fournier. It is necessary, then, in the presence of any affection of the liver of doubtful cause, of unusual course, or of singular development, to suspect late hereditary syphilis—since, next to alcoholism and malaria, it is the most prolific cause of hepatic lesions.

PARIS.

DR. L. BROCCQ.

Selections.

THE LOCAL ACTION OF MERCURY IN SYPHILIS.

It is generally admitted that mercury acts upon organs affected with specific lesions only through the medium of the blood, and hence, in the treatment of syphilis, our chief endeavor is to place the system at large under the influence of the remedy, local applications of the same being regarded merely as accessories. In opposition to this view, Professor Köbner, of Berlin, has published facts which go to prove the topical action of mercury upon syphilitic tissues, and has drawn therefrom some valuable therapeutical indications. Local treatment, he thinks, will often be successful in the removal of large scleroses—such as show themselves refractory to constitutional medication in all its forms. He lays special stress on the superior advantages to be gained in the treatment of indurated chancre by employing lotions and subcutaneous injections of formamide of mercury (1:100). The same measures are recommended for secondary and tertiary ulcers, and for flat condylomata. We have often been astonished at the rapid rapures effected in cases of indurated chancre and condylomata by a combination of internal treatment with the local employment of calomel ointment 6-8 grs.: 30). We attribute them principally to a caustic operation resembling (though less in degree) that which nitrate of silver exerts with so much speed and certainty upon mucous patches. These last, we have also noticed, are quickly healed by the internal administration of mercurial salts. The endermic and hypodermic methods are likewise suitable for demonstrating the local efficacy of mercury, and some remarkable facts have been obtained through their employment. Thus Köbner has seen condylomata at the base of the mammae dwindle and desiccate within six days after two sublimate injections made in their neighborhood, while other similar growths around the anus and in the pharynx remained unaltered. In one

case, where there was a papular syphilide on the shoulder, several injections at the centre of the eruption caused it to whiten rapidly, although another syphilide of the same size, which occupied the lumbar region, underwent no change. It has recently been shown by Zeissl that papulous ulcers, as well as indurated glandular swellings, are very refractory to subcutaneous injections of sublimate, but are readily absorbed *when the injections are made in their vicinity*. Again, in the employment of mercurial frictions, if these be carried out upon the feet of a patient affected with a general papular roseola, the eruption will disappear from the limbs eight or ten days before it leaves the body; and the same difference will be observed between the anterior and posterior surfaces of the latter, if the ointment be applied only on the back. On the other hand, it has been found that if, in syphilitic adenitis, the inflamed gland itself be subjected to this process, resolution will follow much sooner than if the constitutional effects of mercury be produced by either frictions or injections practised upon distant parts. Köbner emphasizes the utility of applying mercurial preparations to different regions of the body, as adjuvants to the internal treatment. It must be admitted, he observes, that all the lesions which survive this latter procedure—the induration, the cicatrices of primary sores, the engorged blood-vessels and glands—constitute so many sheltering-places in which the morbid germs can safely await their opportunities for further multiplication. We should, therefore, as speedily as possible, destroy all these lesions, as far as we have access to them, by the direct application of mercury. Thus the occipital, maxillary, and cervical glands, whose lymphatics are not included within the regions usually subjected to frictions and hypodermic injections, generally remain engorged; and this is often the case even with the inguinal glands after constitutional treatment. In cases of extra-genital infection, the glands corresponding to the inoculated locality are the most obstinately congested, and require the most persevering attention. Köbner has known large cervical swellings, following in the train of labial chancre, to disappear under the local use of a little gray ointment after constitutional treatment had been tried in vain. Nevertheless, even these measures will be unavailing when the swellings are partially due to scrofula, when their existence has antedated the syphilitic infection, or when they are kept up by persistent irritation of their lymphatics—in which last case it will be necessary to find out and remove the cause. Obstinate cervical engorgements are sometimes produced by ulceration of the nasal fossæ.

To sum up, then, the mercurial treatment of syphilis should be both local and constitutional. The former is sometimes sufficient by itself, or is the more rapidly efficacious; and, in every case, the remaining traces of the disease will call for local applications, repeated at proper intervals, until they are as far as possible removed.

Köbner has experimented with Oertel's mercurial soap, with oleate of the oxide of mercury, mercurial plaster, and local subcutaneous injections; they are all irritating to the skin, and are inferior in efficacy to freshly-prepared gray ointment.—L. BECO, *Ann. d. l. Soc. Medico-Chirurg. de Liege*, Jan., 1885.

CANCER IN SYPHILITIC SUBJECTS.

THIS question has been taken up by Dr. Ozenne, who deals with it exhaustively in a recent volume, referring especially to syphilitic cancer of the mouth. This latter is a hybrid disorder arising from the united action of syphilis and cancer. The former disease, when thus associated, is always tertiary, its prior stages having never been observed in direct connection with cancer. The combined lesions

of cancer and syphilis, when affecting the buccal cavity, are of several kinds, among which our author distinguishes three in particular—the cancro-sclerous, the cancro-gummatous, and the cancro-sclero-gummatous varieties.

A. In the cancro-sclerous form, the cancer under its usual aspect is sometimes the first to be manifested; sometimes, though more rarely, it is preceded by the syphilitic lesion; and, after a certain interval, we are confronted by a sort of mongrel condition, compounded of the products of incipient cancer, and the changes due to the sclerous glossitis. The appearance of the tongue is then as follows: The organ is enlarged, and displays the cancerous formation. If this be superficial, as a hard swelling, irregularly shaped, of variable size, and more or less prominent; if the epithelioma be interstitial, the tumor is sub-mucous, resistant, elastic, and seated upon an indurated base of undefined dimensions. In the neighborhood of the cancer are observed either the lesions of the superficial sclerous glossitis—smooth, shining, slightly-reddened indurations, circumscribed, or co-extensive with the mucous membrane—or, more frequently, all the evidences of a dermo-parenchymatous glossitis, whose hardness is diffuse and downward-reaching, so as to impart a peculiar sensation to the examining finger.

We cannot here delineate the affection in all its aspects. M. Ozenne places them under four classes, which he distinguishes according to the manner in which the hybrid structure is developed—*i. e.*, without ulceration; with a dermic sclerosis resembling psoriasis; with superficial ulcers of the mucous membrane, or with cancerous ulceration properly so-called.

B. In the second form—the cancro-gummatous—the lesions are so closely united that the features peculiar to each of them are almost entirely effaced; we have an excavated ulcer with an indurated base like that of a cancer, but without the perpendicular walls or bleeding surface characteristic of the latter. Sometimes, also, other ulcers are found in the vicinity.

C. The third or cancro-sclero-gummatous variety is the most complex; it combines the gumma, the cancer, and the dermo-parenchymatous sclerosis in very various proportions, sometimes manifesting one of these components quite distinctly, and sometimes blending them in utter confusion—thus presenting an exceedingly diversified appearance.

Such are the distinguishing marks of syphilitic cancer of the mouth—marks which are reproduced when the lesion is situated on the tonsil, the cheek, or the lips. As to its functional symptoms, these consist almost wholly in a diminution of the disturbances caused by either of the diatheses when alone present. Thus, hemorrhage is seldom met with, and pain, so frequent an accompaniment of uncomplicated cancer, is generally absent. Despite these advantages, the termination is no less fatal: since, as M. Verneuil has remarked, the prognosis depends upon that of the predominant neoplasm, and this, in the dual affection we are speaking of, is always cancerous. Treatment with iodine should always be resorted to when the existence of a syphilitic cancer is apprehended, as being undoubtedly applicable to the specific element in the disease, but should not be kept up too long, for fear of unfavorably affecting the cancer. The latter is sometimes amenable to surgery. But it must be borne in mind that mercury, so injurious in ordinary buccal cancer, is here also to be absolutely proscribed.

M. Ozenne concludes by citing several cases of syphilitic cancer affecting the nipple, the penis, the testicles, etc.—*Jour. de Méd. et de Chirurg.*, Sept., 1884.

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ALEPPO BUTTON.¹

BY

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Aintab, Turkey.

NOT a great many articles upon the Aleppo button have been given to the profession. The studies of V. Carter, Lewis, Cunningham, Willemin, and others, it is true, have given us a fair view of the nature and the clinical history of this disease; nevertheless, the science of medicine has not yet been sufficiently enlightened upon this subject. Most writers have not had sufficient opportunities afforded them for continued personal observation, therefore it is not surprising that the exact character of the Aleppo button is as yet not fully understood.

During six years' residence in Aintab (on the border of Syria and Asia Minor) where the disease is endemic, I had ample opportunity for the study of this disease, having been myself affected.

Nomenclature.—Before proceeding with the general details of this disease, it may be desirable to note some points in regard to the nomenclature of the Aleppo button.

The word "Aleppo" attached to this affection would indicate that it is confined to Aleppo. Such is not the case, since it also prevails in Alexandretta, Antioch, Aintab, Oorfa, Malatia, Harpoot, Diarbekir, Mardeen, Bagdad, Bassourah, and other Eastern places. In each locality

¹ Graduation Thesis, College of Physicians and Surgeons, New York, March, 1885.

different names are given to it. The Arabs term it "Habb-el-seneh" (one year button), and the Armenians "Daroo" (meaning almost the same thing). In Aintab they call it "Aie Bashi yarasu" (new moon-sore). Khourma yarasu (date sore) is another name, so termed on account of its prevailing in localities favorable to the cultivation of dates.

Some truth may be deduced from the names already given. I.—The sore lasts generally about one year. II.—Different changes are supposed to occur monthly. III.—It is endemic in many places where dates are cultivated. Still neither of these names carries with it any exact idea, and each has its objections.

Lewis and Cunningham have termed it the "Lupus Endemica," and Alibert "Pyrophlyctide Endemica," but these synonyms seem to be entirely out of the way. It resembles somewhat the lupus vulgaris, but nevertheless differs essentially from it; again the pathognomonic symptom of the so-called Aleppo button is not that of burning, nor is the tumor due to the accumulation of a serous fluid under the epidermis, as is the case generally with the pyro-phlyctides.

The word Oriental sore (T. Fox) seems to be better adapted, the only objection to it being that the sore does not prevail over all the Eastern regions. The Delhi sore and Biskra boil, so far as I can learn from authors and travellers, have the same pathological character as the Aleppo button; there may be slight differences, but these are probably due to climate, localities, and the general habits of the inhabitants. The Scinde boil, the sores of Roorkie, Moultan, Lahore, Meerut, and other crowded Indian cities; the boils of Aden, Crete, Yemen, and Cochin-China, says Dr. J. Fayrer, are varieties, if not identical.

However, as the word "Aleppo button" is that mostly used by the profession for the boil found in Syria and Mesopotamia, it will be well to keep it until further research discloses the exact causation and pathology of the disease.

Definition.—The Aleppo button is an endemic indurated and indolent cutaneous disease, without any constitutional symptoms, appearing singly or in number on the exposed parts of the body, as a rule in the form of a papule, which undergoes a series of changes, such as development and ulceration; cicatrizes slowly under the scab, and leaves a scar behind. It very rarely, if ever, attacks the same person more than once.

Etiology and Pathology.—Our knowledge of the etiology of the Aleppo button is at the present very imperfect. We know that it is irregularly distributed over a large area of the Oriental world. Its extension to any new locality by imported contagium is not traceable. When and how it originated in those places where the disease is indigenous is not known. Wherever it prevails, children are the chief victims; even among people not protected by a previous attack, less liability is observed

with advancing age. Infants under one year of age often escape, or if not, they have it in a slightly mitigated form. Sex has no direct predisposing influence; male and female are equally predisposed.

Strangers who have not had the disease before arriving in an area, at the favorable season, where the disease is endemic, are quite strongly predisposed to it, but this predisposition is by no means so strong as it is for the native inhabitants. Many strangers, having been exposed to it for a number of years, do not become affected, while the natives rarely, if ever, escape.

The liability to the Aleppo button, after one attack, usually disappears for the rest of life. Although Willemin mentions several cases who have had it a second time in a mild form and situated on the scar of the primary sore, I think that if a complete cure is accomplished in the primary sore, its occurrence a second time, if not doubtful, must be very rare.

If the disease is artificially produced, it seems not to have a preventive effect on the predisposition.

Various theories have been advanced by writers upon this subject with regard to the active cause of the disease.

Dr. Geber, of Vienna, has attempted by arguments (*Vierteljahresschrift für Derm. und Syph.*, Viertes Heft, 1874), drawn chiefly from the study of unfortunate cases, to prove that the so-called Aleppo button is nothing other than cases of lupus, rupia, serofula, and syphiloderma; but the reasons for rejecting this explanation are overwhelming. I may only add that, if Dr. Geber had stayed longer in Aleppo, or if he had previously known that the natives generally do not take ordinary cures of Aleppo button to doctors for treatment; or if he had had occasion to visit native families and carefully examine the scabbed indolent buttons upon the face of children and the disfiguring scar left almost upon all the elderly persons, he should then have, probably, no doubt of the existence of such an endemic disease.

I myself have had a number of cases of syphiloderma, serofula, etc., brought to me as cases of Aleppo button, after the required time had failed to accomplish the desired cure: certainly, such erroneous statements made by the patients are often misleading.

Dr. Renard has given the following theory: "The exaggerated sudoral secretion, which is the consequence of excessive heat during the summer, produces a morbid condition of the sudoriferous glands, as it is observed also in all glands when their work is excessive, etc." The objections to this theory are very strong; in the first place, the sudoriferous glands, as a rule, are not the seat of inflammation; second, the disease does not only attack those persons who are subjected to excessive sweating; third, it is found in many places where the temperature in summer does not

rise above 90–95 Fahr.; and lastly, were it a disease due to hyperidrosis and temperature alone, it should not be confined to certain parts of the Orient, as these conditions are present almost all over the world.

Scriziat, Alex, and others claim that this button should be compared to cethyma and cachectic rupia which are the result of great debility of the system due to various causes, such as atmospheric and sanitary conditions. It is true that a warm and humid atmosphere, low and badly ventilated houses, accumulation of animal and vegetable putrefying matters, unwholesome and insufficient food, and neglect of the laws of health, are the great causes of human sufferings, but in this particular disease their importance seems to be secondary. Various facts prove that no amount of heat, filth, and bad food alone are sufficient to produce such an endemic disease. There are some places where a dry, mild, and healthy climate exists, yet all the inhabitants, poor and dirty as well as rich and clean, are predisposed to it, with only this difference, that when these conditions exist, they modify the duration and termination of the disease. Other things being equal, the disease terminates more favorably in those who are attentive to dietary and hygienic measures.

Sonrie thinks that the fine siliceous dust of the desert, carried away by winds, penetrates the pores of the skin; and that these particles, producing irritation, give rise to the formation of the buttons. But as there are certain localities which bear the same relation to the siliceous winds and remain unaffected, and as we have various places where the disease prevails and the access of these siliceous winds is inconceivable, we are justified in rejecting such a hypothesis.

The studies of Dr. Weber upon the boil of Biskra, which is considered almost identical with Aleppo button, have led him to believe that “Biskra boil is contagious and auto-inoculable.” If this statement is true about the Biskra boil, and is confirmed by other observers, then Aleppo button would, perhaps, differ greatly from that of Biskra button. I have seen mothers affected with the disease, who have not given the disease to their unprotected children, and *vice versa*. Not unfrequently, travellers, merchants, the students of Central Turkey College in Aintab, and others become affected with the button, go to and from their homes, and mingle with their friends without the slightest precaution, yet no single accident, so far as I know, has ever happened by the transported contagium of the disease. Being aware of these facts, I have no hesitation at all in saying that, if the Aleppo button is ever contagious, it must be in very rare cases. Neither is this button auto-inoculable, in the proper sense of the word. The number of the boils is the same from the beginning until the end of the disease; the excoriations and superficial ulcerations that are produced along the line of the discharging ichor from the primary boil must

not be considered auto-inoculations, because simple cleanliness of a few days will be enough to cure them, and they are always absent when proper cleanliness is observed.

Many writers and observers concur in the old prevailing opinion of the natives, which attributes the disease to the drinking water. It is true that the water of a good many places where the disease exists is very scanty and impure; on the other hand, the disease is also found in many other villages, towns, and cities that have an ample supply of pure, cold, soft water, free from any gaseous smell or contamination with refuse matter.

I am, unfortunately, unable now to give an elaborate statement with regard to the analysis of the water where the button of Aleppo is prevalent, but I will insert here the result of analysis of Oned-Kantara water, published by A. Laveran (*Annal. de Derm. et de Syph.*, Tome I., 1880, No. 2, Avril), where Biskra boil exists. The water in this place used for irrigation contains 2 parts of solids in 1,000, consisting of carb. lime and magnesia, sulph. lime and magn.; chlor. sodium and magnesium, and silicate sodæ. The water used for drinking and other domestic purposes contains only 0.794 solids per 1,000; the salts forming the solid being the same as in the former. From this analysis Laveran rejects the water hypothesis in Biskra button.

To the same conclusion we may reasonably arrive in the case of Aleppo button, and not merely from observing and analyzing the water, but principally from the following valuable clinical facts. 1. The disease, as a rule, makes its appearance in the autumnal months, so that, while strangers may remain with impunity the rest of the year, they may become victims in a few days or weeks in the autumn. 2. It occurs in infants three or four months old, who have not yet tasted the supposed vicious eup.

V. Carter has observed upon specimens sent to him by Weber from Biskra a parasitic organism characterized by a mycelium, with numerous orange-colored particles, pale, round or stellate granulation cells throughout the tissue of the tumor. A. Laveran in his article (*Annal. de Derm. et de Syph.*, Tome I., 1880, No. 2, Avril) about Biskra boil says: "Is it not strange that the organisms which existed in such a large number in the specimens sent to V. Carter were not observed by those who studied the Biskra boil? It has been impossible for us to find the parasite of V. Carter, although we have looked for it in Biskra upon a great number of individuals. MM. Kelseh and Kiener were not more successful than we were. It is probable that the organism observed by V. Carter was of an accidental production."

Specimens of three or four months old buttons, which I had brought

from Aintab, preserved in alcohol, were kindly examined by Dr. G. R. Elliott, but did not show any such organisms as described by V. Carter.

Although the characteristic cryptogams of V. Carter in Biskra boil may have been accidental, since many other observers were unable to find them; and although no such organisms could be found in the specimens of Aleppo button, still the parasitic origin of this endemic disease, after all, is not improbable. We have seen that all the other theories advanced as explanations of its etiology have been unsatisfactory. The clinical history as well as the pathology of the disease indicate that there exists some special cause, and all the others mentioned must be considered as adjuvants. What this special active agent is that produces the disease has not yet been discovered.

As the disease generally appears like mosquito bites in the autumn, it has led the people of some places to believe that the button originates from the bite of certain insects, but no actual demonstration has yet been made to prove this theory.

As a matter of curiosity, I here will mention an accident which happened to one of our family during our residence at Aintab.

Hetoom S., aged 16, had been in Aintab two years and had not yet been affected with the endemic button. One evening in the autumn of 1880, he went to bed at about 9 P.M.; before he fell into sleep, he cried out that something had stung him quite severely. He and those who were around and about him searched for the insect or whatever it might be, but nothing could be found, excepting a small papule upon the posterior aspect of the calf where he had referred the bite. This red papule eventually developed into a regular Aleppo button.

This sting may have been an actual occurrence, or it may have been only a sensation caused by the button already begun.

Those who have travelled during the summer or first autumnal months through Arabia and Mesopotamia, where this disease prevails, undoubtedly remember how the incessant and intolerable annoyance of mosquitoes and other insects intensify the suffering from the scorching sun. In these regions there are found varieties of insects that produce, by a single bite or sting, large indurated lumps which may last for several weeks, and sometimes are followed by ulceration.

Is it not probable that this endemic disease is produced by the bite or sting of some special insect peculiar to certain soils and climate?

The close connection between the time in which this button develops with the time when most insects arrive at maturity; the endemic and non-transportable character of the disease; the origin in the superficial layer and exposed parts of the skin, and the limited geographical distribution of the disease are arguments in favor of this hypothesis.

Microscopical examinations so far made on the Aleppo button, show

that the composing elements of the tumor are, principally, neoplastic cells of the surrounding normal tissue and apparently produced by a process of cell proliferation. It is possible that this excessive cell production is due to the peculiar irritating character of the poison of the insect, which may have injected it; the ulceration which follows the tumefaction is due to disintegration and death of these proliferated cell elements.

Anatomical Characters.—For the anatomical character of the Aleppo button I am indebted to Dr. G. R. Elliott of this city, who, having made repeated sections of the specimens I had given him, furnishes the following report:

“This disease appears confined to the epidermis and corium, extending through the latter quite to the subcutaneous tissue. The area of disease seems composed almost entirely of small round inflammatory or formative cells and epithelial elements. The line of separation between the diseased portion and the surrounding tissue is distinct, there being no gradation between the healthy and diseased tissue. The hair follicles appear intact, and there is no evidence of the disease beginning in the glandular structures. No cryptogams or other micro-organisms are present in sections examined.”

Clinical History.—The development of this disease begins, independently of hair follicles, as a small papule, bearing all the characteristic features of a mosquito bite or acne, and is about three or four mm. in diameter. Its color, which is pinkish, disappears on pressure. The progress of this papular stage remain stationary for some time, as if it were undergoing a period of incubation. After this indolent state has persisted for several weeks, it becomes active; its vascularity as well as its size and tumefaction increase slowly, and its base grows deeper, harder, and larger, and becomes adherent to the surrounding tissues, as is the case with the malignant tumors.

To the touch it is boggy; in appearance it is smooth and glossy; but as the tumor progresses and new elements are deposited in its interstices, it acquires a dark livid coloration, probably due to venous congestion. There is no pain and no general symptoms. Slight sensitiveness exists, and a burning sensation may be felt, but it is of short duration. Itching, which is present in many cases, is sometimes severe, so much so that the continued scratching produces serous oozing; this itching is not so peculiar in adults as it is with children.

As all these changes occur, the centre of the neoplasm softens, and from this degeneration a slight amount of purulent and often bloody fluid accumulates, but not sufficient to cause bulging; later, this small central soft tumor bursts, and gives out a few drops of matter, which, adhering to the orifice, forms a scab of brownish-gray color. This scab is gradually enlarged and thickened by the addition of fresh exudation,

which proceeds from continued ulceration until it nearly covers the whole surface of the induration.

This scab is permanent, and more or less conical, bearing some resemblance to an oyster shell. If the scab is removed, the surface of the sore presents a shallow ulcer, with fungoid or spongy bottom; its margin, more or less ragged, is irregularly oval or circular in shape, and, if left alone, in a few days a new scab is formed. If the scab is undisturbed, it remains, and the discharge of ichor from its margin continues for months, until the entire indurated lump gradually disappears by suppuration and absorption, when discharge ceases. Then the process of cicatrization sets in from the centre of the ulcer beneath the scab, at which time, the latter falling off, some narrow crescentic indurated and encrusted pieces remain around the scar. These pieces are also absorbed



in a few weeks, then the entire cicatricial surface, which was at first tender, of pale-red color, and covered with a thin film, gradually disappears and assumes the appearance of the normal skin, leaving a permanent and disfiguring cicatricial scar.

The size of a well-developed button varies greatly; it may be from one-fourth to two inches in diameter, but the usual size is about one inch; it rarely exceeds two inches. When large, they are, as rule, few in number; when numerous, they are of the minimum size.

The duration, roughly speaking, is about one year; but there are cases that get well in a much shorter period, while others become chronic and last for a number of years. When the size of the button is not very large, and the constitutional condition of the patient is favorable, the duration is generally not more than five to seven months; on the other hand, when the button is large and the system is under the influence of some general vice, the duration is longer.

Complications and Sequelæ.—There is no particular disease that is apt to be complicated with the Aleppo button, though, of course, enlarged glands, with or without suppuration in the neck or elsewhere, and various acute or chronic, local or general affections may coexist accidentally. Libert and others speak of phlebitis, metastatic abscesses, and erysipelas as occasional complications of this disease. Although these may coexist with the button, my experience would not lead me to speak of them as complications; on the contrary, erysipelas, which is common in the East, rarely affects those children who are subjects of this disease.

Much deformity often results either from the contraction of the scar which it leaves or from the destruction of superficial tissues; for example, ectropion of upper or lower lids, distortion of the mouth, stricture of nares, and entire loss of alæ or tip of the nose. The size of the scar is in direct proportion to the ulcerating surface. Its depth and color are quite similar to the scar from a burn. Hair grows fairly well on the scar, provided that the tissues are not much destroyed by escharotics and other severe measures.

Diagnosis.—The differential diagnosis of the Aleppo button is generally so easy that it ought not to be mistaken for other skin affections. In the first place, it is well to ascertain whether or not the individual is a native; if he has ever visited places where the disease is endemic; whether he has been affected before. It is also desirable for us to know at what time of the year the button made its appearance. In forty-eight out of my fifty recorded cases, the beginning or papular state was first noticed in autumn, the remaining two cases beginning apparently in the spring. During the winter, the forty-eight cases presented an indurated tumor, and in the following spring the most prevalent feature was that of suppuration. During the summer, cicatrization generally occurs, though about five per cent become chronic.

After the preliminary history has been taken, a careful examination of the affected surface will enable us to distinguish it from a mosquito or flea bite, and from acne, both of which closely resemble it during the first few weeks. The eruptions caused by these insects are temporary, usually disappearing in a few days. If it is acne, the papule soon fills with a sebaceous fluid or its characteristic comedo, while the Aleppo button has none of these characteristics, and grows slowly.

The button, as a rule, attacks the exposed parts of the body. Its usual seat is on the cheeks, tip and sides of the nose, eyelids, angle of the eye and mouth, ears, or forehead. Frequently it is found on the wrist, hand, foot, forearm, leg, and knee; it never occurs on the palmar, plantar, or mucous surfaces. Its occurrence on the trunk, upper part of the thigh and arm seems to me rather doubtful, although M. Libert in his thesis says: "I was affected on the thigh, axilla, and trunk." He

further adds: "The boil situated in the axilla burrowed under the skin, and produced slight phlebitis, afterward breaking out on the thoracic region on a level with the third rib." I am at a loss to understand this history, having seen nothing like it during my six years' residence in the Aleppo region. So far as my knowledge goes, the button remains always in its original focus, never assumes a serpiginous character, and never travels through the neighboring tissues to burst out at a distance.

Papular and ulcerating syphilides may be confounded with this endemic button in its corresponding stages; but an inspection of the pharynx, mouth, and other portions of the body, as well as the history, will afford us sufficient evidence regarding the character of the disease. I must further add that the number of buttons is generally limited to from one to five, seldom more, though exceptionally there may be as many as twenty. The greater chronicity, comparatively slow growth, the resistance to specific treatment, as well as the limited number and special situation of this button will certainly lead us to a correct diagnosis.

Lupus vulgaris is most likely to be confounded with this disease, inasmuch as its special preference for location, like the Aleppo button, is the skin of the exposed parts, and especially of the face.

The indurated base, greater protuberance above the level of the skin, the thick, conical, browish-gray scab, and the limited duration without medical treatment, are the characteristics of the Aleppo button. A patch of lupus is usually formed by the coalescing of numerous aggregated reddish-yellow or reddish-brown blotches, while Aleppo button ulcer develops by a single red papule, or, if there be more than one, they rarely coalesce.

Lupus is quite a destructive disease, and it may attack the deeper tissues, while this button almost never extends beyond the deep layer of the superficial fascia; finally the button, unlike lupus, never changes in its original focus, the primary papule is always the centre of the growth, and it also never presents in a given patch various stages, such as small papules in one spot, ulceration on the other, and cicatrization on the third, as is commonly the case with lupus.

Scrofuloderma, ecthyma, pemphigus, and other skin diseases are so distinct that it is hardly necessary to mention the differential points.

Prognosis.—This disease, so far as I know, has never proved fatal, though death has in some cases occurred from poisoning by the use of improper remedies. Its tendency is toward recovery within a year in the majority of cases, but there are a number of cases which become chronic and last for many years. Ten of my fifty recorded cases had existed more than a year; some three, some four, and one seven years. Besides these ten, I know of two other cases, one of which had continued about ten years, and the other twenty. In the latter case, the button

had changed its original character, becoming epitheliomatous, and recovery ensued after complete removal. There was no doubt that this epitheliomatous ulcer was the continuation of the original Aleppo button which had existed since childhood.

When the disease becomes chronic, it resembles lupus so closely that it would perhaps not be improper to say that the Aleppo button in some cases terminates in lupus, the principal distinction being that the button is stationary and never becomes so destructive a disease.

Is the Aleppo button inoculable?—According to Russel, the dog, the cat, birds, and almost all animals may be affected. Lundtz admits occurrence only amongst dogs and cats. Willemin has observed it in two dogs only.

Desgenettes has made several trials of inoculation without conclusive results.

Willemin has inoculated sixteen individuals in Aleppo, with the lymph secreted by the human Aleppo button. The inoculated persons were six children of Aleppo, nine adult strangers, and one native of eighteen years, who had already been affected in his childhood. Upon the foreigners, eight were refractory, but with the ninth, as well as with the young native of eighteen years, and also in two children, the inoculation succeeded.

In Aintab, I tried inoculation upon four medical students who had not yet been affected with the disease, nor had they lived in localities where the button prevails. In one of these cases I used the purulent discharge alone, which gave a negative result. In the other three, I used both the discharge and scab derived from one child, and with success. Several days after the inoculations, ulcers began to develop until they reached about one-half to three-fourths of an inch in diameter, and although these ulcers bore some characteristics of the ordinary button, they nevertheless differed essentially in many points. They were more superficial, more inflamed, discharged more freely, and ran an acute course, terminating by cicatrization after several weeks. One of these three cases, upon whom inoculation had shown the best result, was affected by a normal button a year after the inoculation.

It seems to be difficult to arrive at conclusions from a few experiments, but the single case of mine and many other cases that have been experimented upon by others, indicate plainly that, although inoculation of the button may produce certain ulcers which bear some characteristics of the Aleppo boil in an acute form, these artificial ulcers do not give immunity from a second attack, as is the case after a normal attack.

The presence of the Aleppo button in horses, cats, and birds around the Aintab and Aleppo region is quite doubtful. It is possible that

dogs may have it, as it has been noticed twice by Willemin. I saw accidentally one hound which had quite a number of nodules upon its nose, and I suspected it to be Aleppo button, but could not be sure about it.

Treatment.—The treatment of the Aleppo button is both hygienic and medicinal.

Hygienic measures, as in general therapeutics, are in this particular disease indispensable, although I must confess that sanitary measures are not altogether preventive. Still there is no doubt that they modify the severity as well as the duration of the disease. The great proportion of the cases that become chronic, are dirty, serofulous, rachitic, and badly nourished subjects. The influence of hygiene is more pronounced among the foreigners than among the natives. I have noticed that most strangers who live in good sanitary conditions have escaped the disease even when living in the region for ten or more years.

As the disease generally originates in the autumn, special care must be taken in this season. It is not customary in these regions to sleep upon bedsteads. Most natives, as a rule, place their bedding directly upon the ground in the yards or upon the roof of the houses, on account of the troublesome heat in the buildings. Such a way of living seems to be very favorable for the development of the button. The less liability of the disease during the early infantile age among the natives is due, I think, to the care which is taken at this age. The careful mother bandages her babe like a mummy from head to foot and lays it in the cradle. A careless mother often omits this custom for her convenience and takes it in her bed without the usual swaddling. It was mostly in this latter class that I found the Aleppo button under the age of one year.

Therefore, to the sanitary measures, the use of bedsteads and mosquito-nets would be valuable additions.

Various medicines, both locally and general, have been used by natives and other observers, but no drug has yet been found to have a direct effect upon the disease. It is an extremely intractable disease, and although it has all the feature of a local disease, nevertheless it is not purely so; there is no doubt that the entire system, sooner or later, comes under the influence of its specific ferment as a strong immunity from a second attack is produced.

Internal medication is useful in many cases, especially in those where more or less tendency to chronicity exists. Chalybeates and iodides are the most efficacious drugs, especially for children and when combined; in some cases, the addition of cod-liver oil is very useful, particularly if the subject is of strumous or rachitic diathesis. Arsenic and other alteratives are not of great value.

Locally, different medicines must be used in its different conditions. In the earliest stage of the disease, when it is a papule of a few lines in

diameter, destruction with various caustics and escharotics proves to be useful in some few cases. It must always be borne in mind that unless the destruction is thorough, the button will certainly again appear.

In the early stage of the disease, I have tried abscission in several cases with good results, but it is yet a matter of uncertainty whether the button will redevelop after excision.

When the base of the button has penetrated the deep cellular tissue (subcutaneous), abortive measures cannot be used without producing a large scar.

Various pastes made of arsenic, corrosive sublimate, sulphate of copper, and other escharotic agents are used by native physicians and barbers. They make a few applications at the time of ulceration which is followed by inflammation, sloughing, and later by cicatrization.

Any stimulating application during the stage of suppuration will encourage the absorption and consequently hasten the cicatrization, but all these measures, as a rule, are apt to leave a deeper scar; therefore, the less the scab is disturbed the smaller the scar will be.

The best local medicine we have at present is tincture of iodine, which can be applied from the beginning until the end of the button. It is better to apply it all over the tumor, once or twice daily. Its checks its enlargement and shortens the duration.

CASE OF EPITHELIOMA OF THE PENIS; OPERATION.

BY

WILLIAM H. VAN WYCK, M.D.

Surgeon to Charity Hospital.

G. M., æt. 63, native of England; laborer; widower, was admitted to Charity Hospital December 29, 1884. There is nothing in his family history which presupposes heredity, as his parents died of old age; mother at 82 years, father 85 years. He has two brothers living, aged respectively 64 and 66 years, both in good health. Patient has always enjoyed good health; never seriously ill, except from an attack of scarlatina when a child. Had gonorrhœa once when a young man. His present trouble commenced in July last, when he noticed a small spot of incrustation on the anterior and upper part of prepuce which caused him slight pain at times, but none on pressure. From that time on, its progress was quite rapid, ulcerating through the prepuce and involving the glans penis. Pain continued slight up to October, when there was a

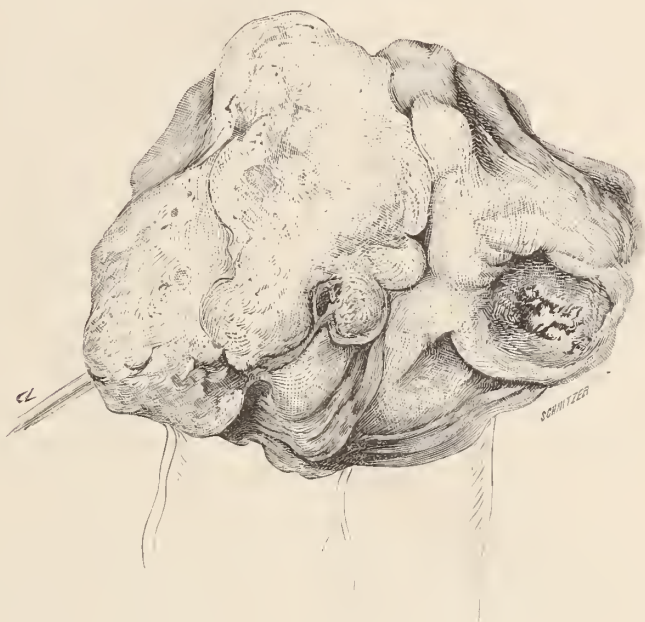
moderate hemorrhage. The pain now became much more severe, and as he describes it, "like a darting shot through the penis."

At the time of his admission to the hospital, the patient was very much debilitated and emaciated, probably the result of neglect and poverty as much as disease, since all the organs of the body on physical examination were found normal, with the exception of the penis, the anterior half of which was increased in circumference; the posterior half normal; the skin relaxed and of a dusky bluish color; glands in left inguinal region not much enlarged, but forming a chain-like elevation in



groin. The glans penis, which is entirely enveloped by the new growth, is as large as a moderate-sized orange, and is nearly at a right angle to the axis of the penis. The neoplasm is made up of large masses separated from each other by deep fissures which are circular and ulcerated, the base being moist and of a gray color. The granulations are flabby and broken down in spots. There is a slight serous-like discharge which is of a putrefactive odor. The masses themselves on the anterior surface, forming part of an arc of a circle, are grayish-white in color, studded by numerous pin-head bloody points. From the apex of one of these grayish-white masses in the anterior surface and to the right, the patient urinates without

any difficulty or pain, passing a stream of nearly normal size. The posterior or under surface is made up of numerous superficial ulcerations with indurated edges and base. It was deemed advisable by my colleague, Dr. R. W. Taylor, who was visiting the service at the time of the patient's admission, to endeavor to improve his condition by extra diet with stimulants and tonics, combined with topical applications before operating. He was ordered to bed, and penis dressed with a solution of the bichloride of mercury, 1: 4,000. Internally tonics, extra diet, and $\frac{5}{8}$ iv. spts. frumenti daily. Under this treatment the patient steadily but slowly improved both physically and mentally, and on March 14 the penis



was amputated about midway between the glans and the pubis. As a preliminary step of the operation, and at Dr. Taylor's suggestion, the penis was transfixed with two long bonnet pins passing through the corpora cavernosa X-like, immediately in front of the point selected for incision, and avoiding the corpus spongiosum. These pins served a double purpose, that of a guide against which the operator's knife could rest and follow, and also as a means of extending and steadying the penis. The corpora cavernosa were cut through, and the corpus spongiosum dissected out, and cut through one-half inch beyond the stump. The urethra was slit back on either side to the stump, the upper half retracting, and the under part reflected back and stitched to the integuments

with six fine silk sutures. The catheter was used for a few days after the operation, and then discontinued, as urine was voided without pain or difficulty.

Simple cold water dressings were applied to the cut surfaces, which healed entirely in about five weeks, leaving an excellent stump with a meatus flush to it. The new meatus admits a No. 23 French sound. In this case, while the prepucce had always covered the glans, there was never any tendency to phimosis, until after the ulceration was well advanced; so phimosis could hardly be regarded as the exciting cause of the disease in this case. In almost all cases reported, there is one or the other, of the half dozen or more causes mentioned in works on surgery, appropriated as *the one*. The etiology, I think, is generally accepted as due to constant and prolonged irritation, no matter what the cause of irritation may be. Demarquay, in his monograph, "*Maladies Chirurgicales du Penis*," Paris, 1877, page 356, thus differentiates true cancer and epithelioma of the penis in the following concise summary. "To sum up, the microscope has demonstrated that cancer of the penis is sometimes true cancer, and sometimes caneroide or epithelioma. Clinical observation shows that these two forms have a very different course, and that their prognosis is far from the same; in truth, in the great majority of cases, if not in all, cancer returns invariably: sometimes in the part originally affected, and sometimes and more frequently in the parts to which the lymphatics of the affected region spread, and finally, in a certain number of cases, the cancer appears in a distant organ. Caneroide or epithelioma is, on the contrary, a local affection which is limited to implication of the neighboring ganglia, is not complicated by visceral lesions, and is susceptible of radical cure by operation." These two forms are, therefore, clinically and pathologically distinct. Out of 134 analyzed observations, I have found 22 cancers and 112 epitheliomas—a percentage of 1 to 5.09. Thus the frequency of true cancer of the penis is much less than stated by Lebert in his "*Traité des Maladies Cancéreuses*;" for this learned pathologist says that scarcely one-third of the affections which he had examined were of a cancerous nature, and that two-thirds were epithelioma.

VENEREAL NOTES.

BY

A. H. OHMANN-DUMESNIL, A.M., M.D.,

St. Louis.

Peri-urethral Abscess.

DR. JNO. WARREN makes the following assertion on page 142 of the JOURNAL for May, 1885. "By some the seat of these abscesses are considered to be in the lacunæ, which rupture externally, leaving a fistulous opening; or they may break into the urethra, but others think these abscesses begin in the connective tissue surrounding the urethra, as they do not impede the passage of urine." About a year ago, I observed a case in which it was clearly demonstrated that the latter may take place. A gentleman called to obtain advice for a case of gonorrhœa in which the discharge was very abundant. Upon examination, I noted that there was present near the peno-scrotal junction a peri-urethral abscess of the size of a large filbert. It was promptly opened and the pus evacuated. It was entirely confined to the connective tissue, and healed kindly and rapidly. There never was the least sign of any fistulous opening into the urethra, and it is most probable that in many of the cases observed, where such fistulæ were found, the pus had burrowed its way, and produced a condition which would never have existed had the abscess been opened early enough.

Syphilitic Tubercles of Meatus and Urethra.

L. Beco (*Annales de la Société Médico-Chirurgicale de Liège*, Jan., 1885) has called attention to the beneficial effects of mercury applied locally. Lately a case came into my hands which illustrated this in a marked manner. A young man suffering from syphilis had been under treatment for a considerable length of time, and still a number of local lesions persisted. Those which proved the most troublesome were tubercles about the meatus, and extending into the urethra about one-quarter inch. They suppurated after some time, and the opposed surfaces had a tendency to adhere, so that whenever the patient wished to pass water, he took a pen-knife and made an opening for the urine to pass. Tubercles existed on the forehead and other places, and were a source of annoyance also. Continuing the general treatment which he had been following, I advised him to make local applications of a ten-per-cent preparation of oleate of mercury. It is probable that he was given a stronger preparation, as he complained of the extreme pain it caused.

However, the daily application of this quickly brought about a change of condition. In less than ten days, the local syphilides had completely disappeared and his skin was clean. In the same case, the induration of the primary sore still remained after an interval of six months, involving a large part of the prepuce, and of considerable hardness and thickness. This also disappeared under the influence of the local treatment.

Case of Persistent Chordee.

I have denominated this persistent chordee from the fact that no treatment apparently had any effect. The subject was a young man of fine build and appearance, who had contracted his first gonorrhœa. He indulged in alcoholics, and chordee suddenly made its appearance one night. He consulted me, and I ordered bromide of potassium internally, and injections of chloral every evening. He did not see me again for several days, when he told me that the trouble had disappeared, but not through the effects of the medicine. For two or three evenings, he had taken three hundred grains of the bromide each evening in the space of about an hour, and had injected the urethra several times with a solution of chloral hydrate. Despite this, as soon as he fell asleep, the painful erection would take place and put him in agonizing torture. The exudation into the spongy tissue was confined to one side, but was extensive and had been very rapid. It subsided in a few days, and the gonorrhœa disappeared in a short time. The anaphrodisiac effects attributed to bromide of potassium did not seem to be demonstrated in this case.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

154TH REGULAR MEETING, APRIL 28, 1885.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. PIFFARD exhibited two dogs which were subjects of

MANGE.

The first one shown was a Gordon setter, which had suffered from trichophytosis two years previously. In this case the patch had been attacked with the utmost vigor, resulting in the cure of the disease, but leaving a spot permanently bald.

The second dog was a Yorkshire terrier that had been brought to him about a week before. In this case the hair had fallen from the greater part of the dog's body during a period of about two months, and the fall was unaccompanied by

any signs of local irritation, the skin not being in the least congested or presenting any abnormal appearance whatever except the loss of the hair. With reference to these cases, Dr. P. remarked that the common word mange was applied to numerous cutaneous affections of the canine family. He said that for many years he had kept dogs, and that several of his dogs had suffered from "mange." Besides this he had examined a good many dogs belonging to friends, and had observed several distinct forms of cutaneous diseases among them. One form, which was by no means common, was clearly an eczema, and was, perhaps, due to overfeeding, lack of exercise, etc. This form was, of course, not contagious. The other forms of "mange" were contagious, and referable to parasites. Dogs suffered from the invasion of itch insects (*Sarcoptes canis*), from lice and from an entozoon folliculorum. Dr. P. had never personally met with any of these, but stated that the follicular parasite sometimes gave rise to exceedingly grave symptoms. Of the phyto-parasitic diseases, ringworm was not infrequently met with, but the most common form of mange that he had met with was not due to any of the causes mentioned. It was characterized by pityriasis, accompanied with pruritus, and in a short time by falling of the hair. The patches were usually circular, which united by extension. The pruritus was quite severe, and led to scratching, with the development of various secondary lesions. This form of disease Dr. P. believed to be due to a phyto-parasite, but he had not given the matter thorough examination. It was a readily curable affection, as almost any of the mange cures in common use would cure it. These were almost without exception composed of the following ingredients: Tar, turpentine and sulphur, with a little oil. Crude petroleum, kerosene, and other substances were sometimes used. In the forms of mange due to animal parasites, the combination above mentioned was very effective. Dr. P. was by no means certain that the last described form of mange was confined to dogs, but suspected that it might be the cause of some of the cases of alopecia furfuracea met with in men. In the human subject the affection was almost always chronic, while in the dog it was an acute affection. There was still another form of mange, exemplified in the Yorkshire terrier shown, the nature of which was not clear.

Dr. Fox, for Dr. F. TILDEN BROWN, showed a case of

PSORIASIS OF THE PENIS.

The patient, a man 29 years old, has had psoriasis ever since he was ten years old. Four years ago he contracted syphilis, and was treated for three years with mercury and iodide of potassium. About four months ago, an eruption appeared in the mouth, on the mucous membrane of the nose, and lower lip. This was seen by Dr. Keyes, who said that it was not syphilis. A few weeks ago a scaly eruption made its appearance on the glans penis. He also has characteristic patches of psoriasis scattered over the body, and elsewhere. On the inner surface of the lower lip, on the hard palate, and on the left pillar of the fauces are white pearly patches.

If this eruption were seen on the penis and nowhere else, it might be mistaken for a lupus erythematosus, and if taken in connection with the lesion in the mouth, without looking elsewhere, syphilis would, no doubt, be suspected.

Dr. BRONSON presented a case of

UNIVERSAL ECZEMA FOLLOWED BY PIGMENTATION.

The patient, a wood-carver, 29 years old, has for the past seven or eight months had eczema, in patches varying in size from one to three inches, occupy-

ing mainly the upper and lower extremities, and also scattered over the body. The peculiar features of the case are the great amount of infiltration present, and the pigmentation of the parts affected. The eruption itches greatly, and there are marks of scratching. On the right side of the tongue are the remains of what appears to have been a syphilide. The epitrochlear glands are slightly enlarged.

The case was shown as an illustration of that class of cases referred to by Dr. Fox at the last meeting, when speaking of eczema modified by syphilis. The lesion was regarded as eczema, but the question was raised whether it might not be an eczematous transformation of a pre-existing syphilide.

DR. PIFFARD showed a case of

SYPHILIS.

The patient had a chancre four years ago, followed by an eruption. He has had the present lesion for about nine months. The left nipple and breast are covered with a scaly and tubercular eruption, the space occupied being about four inches. There is another and smaller patch on the left side of back, beneath the inferior angle of the scapula. The left forefinger, the ball of the thumb, and the soles of both feet are also covered with a scaly and tubercular eruption. One peculiar feature of the case is the occurrence of the eruption on the nipples, and it also presents many points of resemblance to an eczema.

THE NATURE AND TREATMENT OF ALOPECIA PRÆMATURA.

In opening the discussion, DR. PIFFARD said that there were a few propositions which he would mention, and which he believed would be undisputed.

There is a very large proportion of cases of alopecia præmatura preceded by pityriasis, and it was to this form he wished to direct the attention of the members this evening. Pincus was the first one who called attention to the essential connection between pityriasis and alopecia præmatura. He called the disease alopecia furfuracea. Malassez and Chincholle pointed out that in the scales a definite fungus was found in all the cases that they examined microscopically. Dr. Piffard had verified these observations. At that time, Dr. P. did not consider pityriasis to be due essentially to a fungus, and regarded the lesion as a constitutional, rather than a local one. More recently Lassar and Bishop demonstrated that alopecia præmatura could be transferred from man to brute, by taking the scales and hairs from a man, mixing them with vaseline, and rubbing the mixture into a rabbit's skin, and producing a similar lesion. Three or four years ago, Dr. P. had a dog who had mange, and by observing the lesion in that animal, he was satisfied that it was parasitic, due to a vegetable parasite, but not a trichophytosis. In the dog it commenced as a pityriasis, there was considerable irritation, and the animal almost tore itself to pieces, and a considerable amount of hair fell off. The condition was so bad that he thought of shooting the dog. He finally went to a dog doctor who gave him a mixture containing sulphur, tar, and turpentine. In less than a week the dog ceased scratching, and in six weeks the hair was growing.

Unna stated some time ago that he had found sulphur, locally applied, to be of service in alopecia, and had been led to employ it from seeing a veterinarian use it in mange. Dr. P. thought that the mixture above mentioned might be of service to the human pityriasis and alopecia, and for some little time had used it with good effect; it had the disadvantage of possessing a disagreeable odor. It invariably stopped the pityriasis, and its use was frequently followed by a renewed growth of hair, that is, where the pityriasis was a constant feature of the case, but when the pityriasis was not present, there was little or no benefit derived from its use. The question then occurred whether he could not obtain something to take the place of the sulphur and tar. Oil of cade was first used, and afterward oleum rusci, but it is difficult to obtain genuine oleum rusci; then oil of lavender and oil of eucalyptus were used, but it is also difficult to get the latter oil free from turpentine. Naphthol was also used without benefit. The

preparation finally made use of was \mathcal{R} Picis liquidæ, Olei lavendulæ, āā \mathfrak{z} i.; Olei pini sylvestris, \mathfrak{z} vi., M., though in some cases, in the commencement, a little sulphur is employed.

Before concluding his remarks, Dr. P. said he wished to call particular attention to the following points:

Is the disease in its nature parasitic?

Are parasiticides the best remedies to combat the disease with?

If so, what are the best parasiticides?

DR. MORROW remarked that the parasitic nature of the form of alopecia described by Dr. Piffard had not been satisfactorily proven. He doubted whether there was a parasitic element present. Certainly it did not manifest the contagious characteristics of a parasitic disease, as it was not communicable under conditions of close contact, as in the case of persons sleeping together. While pityriasis of the scalp was commonly present or had preceded premature baldness, he had seen many cases of alopecia in which this condition had never existed. On the other hand, many persons have an abundant pityriasis whose hair is thick and luxuriant. He had used the combination of ol. rusci, ol. eucalypti, and ol. terebinthinæ spoken of by Piffard, but with negative results, possibly because the use of the preparation had not been sufficiently long continued. The treatment he commonly employed was the use of salicylated vaseline, two per cent, followed by the application of equal parts of coal-oil and alcohol.

DR. BRONSON said that he would take exception to Dr. Piffard's use of the term alopecia præmatura. He believed that the variety of alopecia known as præmatura, or *presenilis*, corresponded precisely in its pathology to alopecia senilis, differing from it only in that the cutaneous atrophy to which it was due commenced at an earlier period than usual; while alopecia pityrodes, or *furfuracea*, was rather a disease essentially affecting the corneous structures of the skin, including both the hairs and epidermis. In one case, we have to do primarily with an atrophy of the deeper structure of the skin, while in the other the lesion was a form of keratolysis. He believed the disease under consideration to vary very little from *seborrhœa sicca*. He did not think that the parasitic nature of the disease was well made out, and that it did not follow the ordinary course of parasitic affections. He was in the habit of using remedies which produced an alterative effect on the skin, such as salicylic acid, sulphur, and mercurials.

DR. TAYLOR could not find a parasite in any of the forms of alopecia. He had used a bichloride-of-mercury solution, in the proportion of two grains to the ounce of water, after proper frictions with green soap, and had had excellent results, the hair growing and the pityriasis disappearing.

DR. JACKSON said that the experiment of Lassar and Bishop, and the observations of Malassez and others, would seem to indicate the contagious and possibly parasitic nature of alopecia *furfuracea* or *pityrodes*. It should be remembered, however, that another French observer had claimed to have found upon a napkin, hung up in a damp corner of his laboratory, fungi identical with those of Malassez. As yet, the contagiousness of alopecia is not proven. In regard to treatment, he had obtained excellent results in a number of cases where there was thinning of the hair, with marked pityriasis, from the use of an ointment composed of one part of sulphur lotum to seven parts of vaseline. At first this was rubbed into the scalp every night; later, every second or third night, and thus gradually decreased. Besides this, he directed the patient to wash the head every week with the tincture of green soap.

Though not included under the heading for the discussion for the evening, he would say that he recently had had the satisfaction of seeing the hair grow upon the patches of alopecia areata in a case under his care, after two weeks' use of a wash of three parts of corrosive sublimate to one thousand parts of water, rubbed in twice a day. He recognized the fact that in this disease the hair came in its own good time with or without treatment, and did not wish to claim too much credit for the remedy used. He likewise had had good success in two cases of alopecia areata from a twenty-per-cent pomade of *jaborandi*, rubbed in twice a day. This pomade he had also used in alopecia præmatura, but without benefit.

In regard to the mange, he had greatly benefited one case occurring in a mastiff by the use of oil of tar. The disease was of the dry, slightly scaly variety spoken of by Dr. Piffard. The case passed from his observation, and he could not say what the final result was.

DR. SHERWELL said that he had never noticed the connection between pityria-

sis and alopecia, nor had he recognized its parasitic nature. In treating premature baldness he often used tarry preparations, and had employed a mild bichloride-of-mercury solution, not for its parasiticide action, but because it possesses the property of stimulating the glands and increasing the proliferating power of the hair-follicles.

DR. ALEXANDER said that, some time ago, he had been asked to see the llamas in Central Park, who were suffering from a form of alopecia, the hair falling in tufts. In the scales at the bottom of the tufts he found a parasite resembling the *acarus scabiei*.

DR. STURGIS believed that baldness might arise from pityriasis without there being any parasite. He believed that many dog fanciers held that mange was not a parasite, and a common remedy with them was turpeth mineral, the subsulphate of mercury; this was of decided benefit, because of the stimulating and parasitic properties which it possessed. He said that it was difficult to believe that mange could be transmitted from one dog to another if it were merely a pityriasis and not of parasitic origin.

DR. KEYES said that he was inclined to believe alopecia præmatura to be hereditary in some families, and mentioned a family in whom the father and two sons became bald at an early age, always in the same places. Now, if the disease were parasitic, it seemed to him that the parasite must have some peculiar method of selecting identical situations in different individuals. In the persons mentioned, pityriasis preceded the falling of the hair, and there was pityriasis of the beard, but in the latter situation the hair was very thick. The female members of the family had luxuriant heads of hair. He had tried various remedies, among others hypodermic injections of pilocarpine, one-fifth of a grain of the muriate, with no effect on the growth of the hair.

DR. ROBINSON did not think that it was absolutely proven that the lesion depended upon the presence of a parasite. He believed that the scaly condition seen in cases of alopecia præmatura was due to the condition of the patient, and also that the sebaceous glands are affected in the disease. He had used sulphur, according to the method advocated by Unna without benefit, and also given general treatment.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

(From our Special Correspondent.)

REPORT OF THE DEPARTMENT FOR DISEASES OF THE SKIN IN ST. THOMAS' HOSPITAL—LESIONS OF THE NERVOUS SYSTEM ETIOLOGICALLY RELATED TO CUTANEOUS DISEASES—CASE OF URTICARIA PIGMENTOSA—ERYTHEMA MULTIFORME—PURPURA—BROMIDE ERUPTION—SYMMETRICAL GANGRENE—LEPROUS INFILTRATION OF THE EPIGLOTTIS—MYXEDEMA—OLEATES—JEQUIRITY IN DISEASES OF THE SKIN—TREATMENT OF SYPHILIS—NEW METHODS IN THE TREATMENT OF DISEASES OF THE SKIN—THE TREATMENT OF RINGWORM.

ACCOUNTS of the out-patients treated during a year in the special departments of our hospitals are, in some cases, little more than a statistical enumeration, and are hence very liable to be passed over by readers as somewhat dry records of no great interest; it is to be hoped that Dr. Payne's "Report of the Department for Diseases of the Skin in St. Thomas's Hospital, 1883" ("St. Thomas's Hosp. Reports," Vol. XIII.), will not share their common fate, as it contains much matter of interest. Impetigo contagiosa is fully treated of, eighty-six cases having applied during the year; it was found to be in frequent association with purulent inflamma-

tions, viz., conjunctivitis, otorrhea, vaginitis, purulent discharge from nose, and ulcerative stomatitis, and with unhealthy suppurating wounds. Dr. Payne believes that a morbid poison causes the disease, and finds a favorable soil in the tissues of cachectic persons, especially children, and has found micrococci in the serous fluid of recent vesicles. Psoriasis is not considered to be connected with gout, as it is common in countries where the latter is rare, and "it hardly logical to assume that what occurs rarely is the cause of what occurs commonly," the occasional co-existence of both diseases in the same person being probably a coincidence only. Heredity was traced in one out of every four cases. Lichen circumscriptus is said not to be very uncommon, and seems to be connected with the wearing of woollen garments next the skin; no fungus could be found on microscopical examination. On the difficult question of the nature of lupus erythematosus, which the author would prefer to call "Cazenave's Disease," he expresses the opinion that the affinity with lupus, though asserted by eminent authorities, remains to be proved. The paper concludes with a full account of a remarkable case of xanthelasma multiplex.

"Lesions of the Nervous System Etiologically Related to Cutaneous Disease" (*Brain*, Oct., p. 342) is the title of a paper by Dr. Radcliffe Crocker, in which he gives a long and careful review of the present state of our knowledge, based on the works of Erb, Schwimmer, Charcot, Leloir, Weir Mitchell, and others. He comes to the conclusion that less serious consequences ensue from cutting off the nervous supply than from irritant or inflammatory lesions of parts of the nervous system that affect the skin; that the kind of eruption produced by the nervous system varies greatly, often without evident reason, when the nervous defect is apparently the same in place and kind; that the same eruption may owe its origin to any defective link in the nervous chain, from the centre to the periphery; that the same kind of nervous lesion that at one time appears to excite an eruption or other nutritive defect in the skin, more often produces no change at all; that lesions other than atrophy which result when innervation is abolished are often traceable to external injurious influences, which the tissues, when unprotected by the nervous system, are unable to resist; but we know nothing of the conditions which determine the nature of the eruption or other skin defect when the nerve lesion is irritative, nor what it is that determines whether there shall be any eruption, or none at all; this uncertainty of effect suggests that the nervous influence is indirect. The cerebral effect appears to vary according to whether its control over the vaso-motor centre is increased or decreased, and according to the secondary changes it induces in the cord; no localizing lesions have yet been found for its influence on the vaso-motor centre. In the spinal cord the fibres that preside over the nutrition of the skin are bound up with the sensory fibres, and are therefore mainly in the posterior columns; outside the cord the path is by the posterior roots, the spinal ganglia, and the sensory fibres, and that lesions of any one or more of these may lead to changes in the skin.

Urticaria Pigmentosa.—A drawing of a "Case of Urticaria Pigmentosa," was shown by Dr. Radcliffe Crocker to the Clinical Society, on Oct. 10. The patient was a girl, four and a half months old, in whom the disease had begun at the age of three weeks, coming out at first as tubercles, singly or in groups. Each lesion was the size of a small pea, yellowish-brown, with a pink areola; on some a small bulla was formed, the contents of which were absorbed in a few days, leaving a permanent tubercle of a yellowish-red color, varying in size. When seen they were found to be from a hempseed to a bean, and brownish-red

to pale fawn, the older ones being paler; itching was not present at first, but had been so latterly. The eruption covered every part of the body, including the palms and soles, but was thickest on the trunk and neck; a few shrank a little, but most remained unaltered, except that fresh vesicles formed on some; there were never any ordinary wheals, nor was factitious urticaria present. The child died of bronchitis eight months after it was first seen, but signs of improvement in the skin had commenced about a month before death. Dr. Crocker remarked that while cases like this were very unlike urticaria, they were brought into closer relationship with that disease by intermediate cases; moreover, nearly every one of the special features of urticaria pigmentosa was seen in exceptional cases of ordinary urticaria.

Erythema Multiforme.—Dr. Spencer's "Notes of a Case of Erythema Multiforme" (*Brit. Med. Journal*, Sept. 6, p. 465), describe a case occurring in an anæmic blonde girl, aged 19, presenting the usual characters of the eruption, and subsiding in twelve days, followed by branny desquamation; but there was considerable fever, the highest point reached being 104° on the ninth day, and the highest pulse rate 130 on the eleventh day. As the eruption was preceded by severe lumbar pain, variola was at first suspected, a suspicion which was soon set at rest by the absence of pustulation and the character of the rash.

Purpura.—An interesting case of "Purpura" was communicated to the Pathological Society by Dr. Wickham Legg, on Oct. 21. He showed preparations of the tissues from a man, aged 36, who had syphilis two years before his death, and was also a free drinker; for six months before death he had undergone considerable privation, and had had little vegetable food; he had a rash, probably purpuric, which increased about three weeks before he died, with vomiting and diarrhoea. On admission, there was well-marked purpura over the whole body except the face, and swellings of the joints; both decreased at first, but a recrudescence of the purpura took place accompanied by urticaria, hæmorrhage taking place into the wheals in a few hours; this eruption began at one elbow, and spread over the whole body. At the necropsy extensive ulceration of the intestines was found, beginning four feet from the duodenum and extending to the rectum; this was not uncommon in fatal purpura. Microscopical examination showed great numbers of colored corpuscles in the connective tissue of the skin, and around and within the sweat-glands, hair-follicles, and sebaceous glands; there were also large masses of colored corpuscles so disposed as to make it probable that they were caused by ruptured vessels; in the papillæ and close under the epidermis, the vessels were distended and full of blood; the outer and middle coats of the arteries in the areolar tissue were infiltrated and much thickened. Dr. Legg said that against scurvy, there was no swelling of gums and no improvement under treatment; against alcohol, no changes in the liver; the swelling of the joints was in favor of rheumatism, as was also the purpura urticans, but the disease of the vessels was against this view; he thought this and the purpura were due to syphilis. Dr. Wilson Fox had recorded one case of purpura occurring in combination with syphilis, in which he had found the same changes in the blood-vessels of the skin. Dr. Buzzard said he did not think the case was scurvy, and had never seen such a condition in syphilis, but had met with it in purpura from alcohol.

Bromide Eruption.—Dr. Carrington showed a drawing of "Bromide Eruption" to the Clinical Society, on Oct. 24. The child was born healthy, and remained so to the age of ten months; it then began to suffer from convulsions and symptoms which seemed to point to meningitis, and was given a mixture con-

taining a little more than one grain of bromide of potassium in each dose, every four hours; for a time it was given every three hours, and for a time bromide of ammonium was substituted. The medicine was persisted in for about seven weeks. The eruption appeared as small red papules, which in three or four days became the size of penny-pieces, and the parts affected were the buttocks, legs, and thighs, and to a lesser extent the scalp and face; the smaller spots were bright red and smooth, the largest dark brownish, circular or elliptical, with a sharply defined edge at least one-eighth of an inch in thickness; they were spongy, but without fluid contents. The treatment was half a grain of iodide of potassium and one minim of Fowler's solution, three times a day; in a fortnight there was great improvement, some spots had disappeared, and were represented only by pinkish discolorations, and the others were much shrunken, and nearly on a level with the skin: no new ones appeared, and recovery was uninterrupted. Dr. Duckworth thought this case remarkable as the sebaceous glands were not specially involved. Dr. Stephen Mackenzie said the appearance of the eruption might be deferred till some time after beginning the drug, and might continue two or three weeks after its cessation. Dr. Barlow corroborated this, and thought the explanation was the existence of an individual idiosyncrasy preventing due elimination of the drug; he had seen the rash occur three weeks after the medicine was stopped, and the urine then contained bromine. Mr. Morratt Baker pointed out that the worst cases of iodide rash occurred in patients with advanced kidney disease, and Sir Andrew Clark said this was a frequent cause of the retention of certain drugs in the system for a lengthened period.

Symmetrical Gangrene.—Mr. Young showed a case of "symmetrical gangrene" to the Manchester Medical Society, on Oct. 1. The patient was a man aged 21, with gangrene of almost the whole of the distal phalanges of the fingers on each hand; beyond abnormally smooth and glossy skin, the thumbs were unaffected. Onset was characterized by intense pain and lividity, before which the fingers became very cold and pale, were more or less numb, and there was some loss of power. The patient was very anæmic, and had always been weak, and suffered from cold extremities, but was otherwise healthy; the organs and secretions were found healthy, but the blood contained an excess of colorless corpuscles; the family history pointed to a probability of inherited syphilis, of which, however, he showed no sign beyond slight deafness.

Leprous Infiltration of the Epiglottis.—A valuable "Report on Leprous Infiltration of the Epiglottis, and its Dependence on the Bacillus Lepreæ," has been issued by Dr. Thin (*Brit. Med. Journ.*, July 19, p. 109). He shows that the special habitat of the bacillus is the lymph or colorless blood-corpuscle, as proved by the occurrence of cells containing bacilli within lymphatics and blood-vessels, and does not doubt that the large leprous cells found in the connective tissues, and largely forming the nodules of leprosy, are due to a slow growth of migratory cells infected with the bacillus. In the epiglottis the cartilage and epithelium were found uninvaded by the leprous growth. The paper is illustrated with six excellent woodcuts, and gives details as to the best mode of demonstration.

Myxœdema.—The subject of "Myxœdema" continues to attract attention. Dr McCall Anderson has recorded a case (*Glasgow Med. Journ.*, Oct., p. 303) which was very considerably improved by the following treatment: the patient was shampooed daily for half an hour, olive oil being used; every third day she had alternately the following: 1st day, vapor bath; 2d day, pilocarpine gr. $\frac{1}{4}$ hypodermically; 3d day, a hot electric bath for half an hour; she also took a mixture of

arsenic and strychnia. Each of the above three methods made her sweat profusely. The electric baths were stopped after six weeks, and in less than three months she left the hospital much better. Dr. Donald Fraser's "Case of Myxœdema with recovery, which was marked by profuse perspiration" (*Med. Times and Gazette*, Oct. 25, p. 572), was most remarkable, as the sweating, which was extremely profuse, was quite spontaneous, and seems to have continued for two years. At the Clinical Society, on Oct. 24, notes of a case of Myxœdema were read by Dr. James Anderson. It occurred in a married woman, aged 40, and was of twelve years' duration. The points of interest were (1) a history of commencement from hemorrhage after extraction of teeth, lasting twenty-four hours, and a general hæmorrhagic tendency, shown by menorrhagia and bleeding of the gums; (2) an occasional state of nervous restlessness, apparently incompatible with the general character of the disease; (3) the ocular condition; she was slightly hypermetropic, had slight peripheral opacity of the left lens, and both retinae presented a hazy appearance surrounding the vessels, especially in the neighborhood of the disc; the appearances differed entirely from those of past neuritis or retinitis, and did not interfere with perfect vision; (4) she felt greatly better after jaborandi, although there was no apparent improvement in her outward condition, but there was a steady and marked increase in the amount of urea excreted, which doubled itself during treatment. In the discussion, Dr. Sémon referred to the effects observed to follow excision of the thyroid by Kocher, and especially arrest of growth when the operation had been performed before development of the body was completed; recently this had been confirmed by Prof. Bruus, in the case of a patient, aged 28, whose thyroid had been removed eighteen years before on account of goitrous degeneration; growth in length had been entirely arrested since the operation, and he had become a cretinous dwarf, only the dimensions of the head being those of a man of his age; he presented the character of myxœdema and also that of cretinism, and obviously both were connected with loss of the function of the thyroid. Dr. Hale White referred to the necropsy of a case (communicated in full to the Society on Feb. 13) in which marked degeneration of the thyroid was found, and he considered this to be the cause of the disease, because all the other changes were probably secondary. In connection with this subject, Mr. Victor Horsley's lecture on "The Thyroid Gland: its Relation to the Pathology of Myxœdema and Cretinism, etc." (*Brit. Med. Journ.*, Jan. 17, p. 111), may be referred to. He found that extirpation of the body in monkeys gave rise to peculiar psychological and somatic changes which were closely analogous to those of myxœdema.

A variety of therapeutical papers have recently appeared. Dr. Shoemaker, of Philadelphia, has written on "Oleates, further investigations into their nature and uses" (*Brit. Med. Jour.*, Oct. 18, p. 749); on "Jequirity in Diseases of the Skin" (*Lancet*, Aug. 2, p. 185), and on "the Treatment of Syphilis" (*Lancet*, Sept. 6, p. 406). The latter subject forms a large part of Mr. Alfred Cooper's paper on "Syphilis, its prevalence, nature, and treatment" (*Brit. Med. Jour.*, Oct. 18, p. 755). He regards excision of the primary induration as useless, as it is the local manifestation of constitutional infection, and thinks the earlier mercury is given the better, and that the most convenient way is to give blue pill by the mouth; mercurial treatment should be prolonged over two years, with intervals of discontinuance, and he thinks no patient should be allowed to marry until he has undergone such a course, and has subsequently remained free from symptoms for a year at least.

"The Treatment of Ringworm" forms the subject of several short notes

and memoranda. Dr. Alex. Smith (*Brit. Med. Jour.*, Nov. 1, p. 858) still thinks oleate of mercury one of the best remedies for chronic cases, but has not had much success with oleate of copper. He has lately been trying what vehicle penetrates most deeply into the hair-follicles, and thinks it is chloroform, which dissolves out the fatty matter. During the last year he has used a solution of seven grains chrysophanic acid (chrysarobin) to the ounce of chloroform in all cases of recent ringworm, and believes it is the most efficient treatment he has yet tried. The small patches should be carefully marked out by cutting the hair very closely over them, and the solution should be well pressed and dabbed into the places with a minute sponge mop for five minutes two or three times a day, according to the amount of irritation produced, the aim being not to produce scabs, but to get the solution to penetrate deeply. The mop should not be much larger than a big pea, and should be continually dipped into the chloroform bottle, as the solution soon evaporates and leaves the yellow acid dry on the place. Great care must be taken that the solution does not run on to the forehead or into the eyes, and that the person using it does not inhale the vapor; he always gives full directions about the care necessary, and only employs it to small places of the disease. The places should be well washed every morning with hot soap and water, to remove any sebaceous matter or crusts, and the hair should be kept closely cut until new hair appears, generally two or three months; but the remedy should be continued till all diseased stumps have come out. Mr. Malcolm Morris (*Brit. Med. Journ.*, Nov. 15, p. 961) points out that he had recommended chloroform as a solvent in 1881 and several times subsequently. He has used various drugs, as thymol, salicylic acid, boracic acid, perchloride of mercury, etc., in chloroform, in ether, and in spirits of wine, and believes that cases yield more readily to this than any other treatment. Almost all authorities recommend washing the scalp with hot soap and water, but he has found that this often conduces to the spreading of the disease; for the last year or more he has always given strict injunctions that the scalp is not to be touched with water or soap. It is easy to understand that spores can be carried from one part of the head to another in soap and water, and so propagate the disease. Dr. Bernard (*Brit. Med. Journ.*, Nov. 22, p. 1,013) cannot agree that washing the scalp is prejudicial. In one very severe case, after trying perchloride and oleate of mercury, chrysophanic acid, and sulphurous acid, he gave up all active treatment, relying solely on washing the head twice a day and sometimes oftener with soft soap and tepid water. The result was most satisfactory: in a comparatively short time the disease gave way, the bald patches soon becoming covered with hair; he thinks petroleum useful. Dr. R. Liveing (*Brit. Med. Journ.*, Dec. 13, p. 1189) used oleate of copper about two years ago as a soft ointment in over 100 cases; it was fairly tried for a year, but the result did not come up to his expectations, and he concluded that it was not equal to oleate of mercury as a curative agent. There was also the less serious drawback that the friends objected to the brilliant color of the ointment, which called attention to the fact of the children having ringworm, although, in one sense, this was an advantage. Subsequently he used an ointment of soft soap and salicylic acid (3 ss. to 3 i. in ℥ i.); this turns brown if kept long and is moderately successful. In 1871 he recommended hyposulphite of soda lotion (3 i. to 3 iss. in ℥ i.) as a useful watery application, and still thinks it the best of its kind. With regard to washing, when an ointment is being used it is usually better not to wash the head very often, because then the ointment does not penetrate so well as when the head is only washed once a week: Free washing with soap and water is a good preventive, and he

often advises parents who have ringworm in their family to wash daily the heads of those children who have as yet escaped the disease, and has scarcely ever known ringworm spread when this is carefully carried out. Hebra used to treat ringworm with soft soap. Ringworm is unwittingly propagated by hair-dressers; children with the disease (both known and unknown) are constantly taken to have their hair cut, a brush and comb are used, and then used again for the next customer, who may happen to be a child. The only safe plan when children are taken to have their hair cut is to take also a comb and brush, the latter being the most dangerous in propagating the disease. In a further communication on the same subject (*Brit. Med. Journ.*, Jan., 17, p. 126), Dr. Alder Smith points out that it is common for children who have ringworm to be taken to the latter, and to be allowed to try on numerous caps, which may thus become sources of infection. The most important point to remember is, however, the fact that many children are still permitted to mix freely, in schools and elsewhere, who have chronic uncured, and often untreated ringworm of the head. He gives the result of examination of boys presented for admission to the large school of Christ's Hospital for a period of ten years; no less than eight per cent of the applicants, aged between 8 and 10, had ringworm of the head, and, as a rule, unknown to their parents. Many of these children are rejected a second, third, or even a tenth time, but many of them had been attending other schools, and had certainly been mixing with other children.

CAVAFY.

LONDON.

Selections.

THE ETIOLOGICAL RELATIONS BETWEEN SYPHILIS AND TABES DORSALIS.

THE author's opinion as to the existence of an etiological relation between syphilis and tabes dorsalis was made public several years ago. He is now induced to return to the subject by his observation of two cases possessing more than ordinary interest in connection with it. The first of these came under his care last summer, in the person of a very intelligent merchant of middle age. The ataxic symptoms had made their appearance three or four years before, and were now strongly marked. Although the patient's general strength was undiminished, he could get about only with the aid of a cane, stepping unsteadily with a kind of "spring-halt." When standing with his eyes shut he swayed about heavily. Tendon-reflexes entirely absent; single movements jerking and uncontrollable. There were also ischuria, necessitating frequent catheterism, nocturnal enuresis, and complete impotence. Strabismus and diplopia had existed for about six weeks, having preceded the full development of the ataxy. As causal influences in this case, heredity, depressing emotions, and over exertion of the limbs were certainly excluded. The patient could give no history of undue exposure to cold. He was himself inclined to attribute his disorder to sexual excesses, but as these had been confined to the period of youth, and he had been happily married for seventeen years, I was compelled to disagree with him. In 1865, how-

ever, he had contracted an indurated chancre. This, as well as another which appeared subsequently in its neighborhood, had healed in about six weeks under local treatment and the internal administration of mercury. It was not until 1870 that constitutional symptoms began to be noticed. They consisted of ulcers in the nostrils—which occupied two years in healing—a perforation of the nasal septum, and gummata in the face, and constituted the first links in an almost unbroken chain of syphilitic phenomena which extended over fourteen years. After ten years of this general contamination, appeared the precursory signs of what by degrees was developed into a typical form of *tabes dorsalis*. *The idea of an etiological connection in this case between the specific malady—ultimately so formidable, though so mild at the outset that its earliest manifestations were evidently overlooked—and the disease of the spinal cord, is one which must have occurred to any physician.*

The second case possesses greater significance. On the twentieth of March last, a journeyman blacksmith aged 72, presented himself at my clinic. He was in a greatly reduced condition, and exhibited in a marked degree the three characteristic symptoms of restiform degeneration of the posterior cord, viz., *unsteadiness of gait, with disorderly movements; swaying about when the eyes were shut, and abolition of the patellar tendon-reflex*. In addition, his lower extremities were almost insensible to contact, while apparently retaining their perceptions of temperature and pain. The functions of the upper limbs were fully preserved, and the territory of the cerebral nerves had almost escaped invasion. In the sulcus behind the glans penis was a small cicatrix with clear periphery. The lungs and bowels were in an advanced stage of tuberculosis. The following history was elicited: “Since his apprenticeship the patient has suffered from rheumatism in his limbs, brought on by the exposure incident to his occupation, but during the past twenty years the pains have seldom been experienced. The first symptoms of *tabes dorsalis*—*numbness and formication of the legs*—date from two years ago. They were soon succeeded by unsteadiness in the dark, with danger of falling; his legs, also, easily became fatigued, and his gait was uncertain in the daytime, so that he was obliged to give up his work. Four years ago, however, as we learned from his former employers, he was able to stand firmly and walk long distances. The lung troubles have lasted a year; abdominal pains with bloody stools, only a few months. Four years ago—*i. e.*, at the age of 68—he contracted syphilis, for which he underwent treatment at the Breslau Dispensary for Venereal and Skin Diseases. The dispensary records show that he was admitted Oct. 25, 1880, and discharged as cured on the 19th of the following month. ‘*Diagnosis. Lues; Sclerosis; exanthema maculo-papulosum.*’” The post-mortem examination on the second of last May disclosed, beyond the slightest doubt, a typical degeneration of the posterior columns of the spinal cord.

While not presenting the above case as direct proof of an etiological connection between syphilis and *tabes*, I would ask whether it does not suggest a forcible warning against wholly excluding the possibility of such connection, as certain prominent authorities have attempted to do. In this patient we have seen that the first decided symptoms of the spinal affection were manifested when he was 70 years old, and a few months later unmistakable ataxic phenomena supervened. The development of *tabes dorsalis* at so advanced a period of life is an extremely rare occurrence—that is, *when its existence is afterwards anatomically demonstrated*. Every single influence which can give rise to the disease was found to have been inoperative in this instance, until the patient had reached an age which might almost have been supposed to guarantee his exemption. After an

attack of intermittent in 1868, he continued in perfect health down to 1880, when he contracted syphilis. Such an accident, occurring to so old a man, naturally gave rise to a suspicion that sexual excesses might have contributed to the final result; but this hypothesis was steadily contradicted by the patient. *Under these circumstances, may we not be justified in regarding an etiological connection between the affection of the posterior cord and the specific disease, contracted three and one-half years before death, as possible, to say the very least?*

The greatly diminished severity of the secondary symptoms in cases of tabes dorsalis with syphilitic antecedents has been noticed by various authors.

The *statistical estimate* which I next proceed to exhibit is based upon one hundred hitherto unpublished cases selected from my clinical records, and including none but unquestionable instances of typical tabes dorsalis, in which the presence or absence of syphilitic antecedents had been thoroughly ascertained. In fourteen out of these one hundred cases, the diagnosis of restiform degeneration of the posterior cord had been confirmed by post-mortem examinations, which in five of the fourteen had also established the pre-existence of syphilis. Of the one hundred tabetic patients, forty-three had suffered from secondary symptoms. The mean length of time which elapsed between the onset of syphilis and the earliest ataxic phenomena was about eight and a half years. From a clinical point of view, no difference whatever was discernible between tabes dorsalis in the syphilitic and in the non-syphilitic subjects. Since this disease always depends essentially upon a restiform degeneration of the posterior cord, it would be as unreasonable to expect that its symptoms should vary according to its mode of origin, as to look for a similar difference between cases of cirrhosis of the liver, when due respectively to syphilis and to alcohol. And in neither instance can the non-success of anti-specific treatment be accepted as important evidence.

The above statement is claimed to be the result of careful and scientific scrutiny. Against the valuation which I would place upon it, but one plausible objection can be urged, viz., that the total number, 100, is too small to warrant a definite conclusion. But many trustworthy observers, more especially Erb, have reported even a higher percentage of syphilis than this among tabetics, while opposing estimates have been founded for the most part upon statistics drawn from an earlier period, when patients were subjected to no special examination as to their syphilitic antecedents. If it be alleged that the 43 per cent of syphilis upon which I rely is no larger a proportion than may be found unassociated with tabes, I can point to the result of special investigations showing that, among male subjects at large, between the ages of 25 and 40, both those in good health and those laboring under any kind of disease excepting syphilis, only 12 per cent had ever had the latter. Erb, among 1,200 males over 25, found only 10 per cent of syphilis. This difference appears to me so strongly marked as to render a causal connection between syphilis and tabes exceedingly probable. *Forty-three per cent of secondary syphilis among non-tabetics is a proportion absolutely unheard of in this country.*

I am aware that there are some who deprecate the numerical method as applied to the solution of this important question, and who call for clinical and anatomical proofs. It has been already explained why the former mode of demonstration is not applicable in the present case. Pathological anatomy is also inadequate to its requirements. Microscopical examinations have shown conclusively that there is no such thing as a peculiarly syphilitic affection of the posterior columns. Yet, although specific disease cannot be regarded as a direct cause of the medullary sclerosis, it is very prob-

ably etiologically connected with it in another way. It is readily conceivable and appears in fact to have been proved by recent investigations, that syphilis, which so destructively affects the blood-vessels of the brain, is also not without its influence upon those of the spinal cord. If this be so, the disease will result in lessening the resisting capability of the cord, and perhaps this lessening process may take place before any alteration of the vascular structure is anatomically discoverable. Under such conditions, exposure to cold, excessive fatigue, and other causes which undoubtedly tend to impairment of the cord, will, in many cases, be borne without detriment to the latter, owing to slight compensatory changes which take place within its substance. The occurrence of such compensation must largely depend upon a healthy functional condition of the vessels concerned—and thus we see how syphilis may act by rendering the cord more subject to hurtful impressions—in short, by endowing it to some extent with a *specific predisposition*. The lowering effects of syphilis upon the system at large need not here be considered, since many patients in the earlier period of tabes enjoy the fullest constitutional vigor. Since, as we have seen, the spinal cord, in “syphilitic tabes,” is not specifically affected in any direct manner, and even in the initial stage of the complaint has already undergone a deep-seated process of degeneration, it is not surprising that anti-syphilitic treatment has shown but little efficacy in this direction. According to my experience, *tabetic patients with atrophy of the optic nerve bear mercury badly*. In other cases, we shall be able to avoid any evil results from the remedy, by administering it in strict accordance with constitutional peculiarities. But few “cures” of tabes dorsalis by anti-syphilitic measures are on record. My own practice has yielded only a single instance of the kind. In 1869, a vigorous, florid-looking officer, thirty years of age, was sent to me by my esteemed friend, Professor Hermann Kohn. In 1863, he had a chancre, which he described as induration, although he could give no account of secondary symptoms. The sore healed in about six weeks, under purely local treatment. When I examined him, he presented a typical case of advanced tabes dorsalis, with very considerable ataxia, and a remarkable diminution of tactile sensibility. Within two months, under galvanism and the use of potassic iodide, he was restored to perfect health, and has since been advanced to a higher military position. Not a solitary trace of locomotor disorder is now to be detected. I have no doubt it would be quite correct to say that a “positive cure” has been effected in this case. Yet I do not believe that, even here, a sclerosis of the posterior columns was actually removed, but rather that they had been secondarily involved in a syphilitic affection of their meninges, which mimicked very closely almost all the symptoms of tabes.

Since, then, it cannot, with absolute certainty, be determined from the symptoms alone, in every case of locomotor ataxy apparently connected with syphilis, whether the disease consists in an incurable primary degeneration of the posterior cord, or in a curable disturbance of its functions, resulting from specific lesions, anti-syphilitic treatment of the same will always be in order, unless positively contraindicated in some way.—OSCAR BERGER, *Deutsche med. Wochenschrift*, Jan. 1 and 8, 1885.

DANGERS FROM THE EMPLOYMENT OF VULCANIZED RUBBER CLOTH IN THE TREATMENT OF ECZEMA.

DR. JULES SIMON lately advised this method of treatment in the case of an infant five months old, affected with eczema impetiginosum. The disease had invaded the face, forehead, scalp, neck, and upper portions of the back and chest.

After one day's application of the vulcanized cloth, there were burning heat of the head, elevation of bodily temperature, and sleeplessness, while a salivary discharge which had previously been very abundant was almost wholly suppressed. Next day the eruptive surface was of a bright-red color, and bled at every renewal of the dressing. The child was prostrated, its fever was considerably higher, and urination was markedly diminished in amount. On the third day, the debility was extreme, the face had a jaundiced appearance, the features were contracted, and the eyes sunken. On the fourth day, the high temperature was succeeded by coldness, especially of the extremities; and as the symptoms just detailed were attributed by Dr. Simon to the action of sulphide of carbon, which had not been sufficiently removed from the cloth in the process of manufacture, he ordered the material to be replaced by a silken fabric stiffened with gum. From that moment a rapid improvement set in; the child recovered its strength and activity; the eczematous surface ceased bleeding; in ten days there was a gain of 220 grammes in weight, and the eruption gradually disappeared—showing that the employment of silk, under such circumstances, confers the same advantages as that of vulcanized rubber, while free from the dangers accompanying the latter.—*Rev. de Malades de l'Infance*, Nov., 1884 (*Lyon Médical*).

THE MICROPHYTES OF THE NORMAL SKIN, AND THEIR RELATION TO AREA CELSI.

BELIEVERS in the parasitical origin of area Celsi have had to meet the objection that the fungus which they connect with the disease had either not been botanically defined at all, or else, in some cases, had been identified with the *trichophyton tonsurans*, while in others a growth not recognized as sufficiently characteristic had been found in the neighborhood of the affected localities. This, of course, could be replied to very plausibly by demonstrating the presence of a vegetable product at the very bases of the hair-follicles, thus apparently explaining all the peculiarities of area Celsi, the falling of the hair from isolated spots, and the difficulty encountered in treating the disease. It only remained to be determined why the morbid elements were never found in any amount on or about the surface of the diseased parts, since their earliest extension must necessarily take place from that surface downwards. The author now reports that he has examined patches of recently developed area Celsi, which was easily curable by a simple application of carbolic solutions, the disease being thus proved to be still confined to the surface.

He detected in two cases an abundance of superficial spores, from which it might be inferred that the affection actually follows the course just indicated. The discovery, however, of precisely similar spores on healthy scalps, forbids the positive assertion of a causal connection between those products and area Celsi. On the other hand, it leaves the idea of such a connection still unrefuted, and although tropho-neurotic cases of area are undoubtedly met with, yet the simultaneous occurrence of the complaint among individuals respectively belonging to the same family, the same school, the same locality, or subject to the same conditions in other respects, speaks strongly in favor of its parasitical nature—which, of course, can be finally made manifest only by scientific culture and inoculation of the fungi.—C. PELLIZZARI, *Bollet. della Soc. Tra I. Cultura della Sci. Med. in Siena*, II., 1884 (*Wien. Med. Woehensch.*).



Dr. Hyde's case of congenital naevus
lipomatodes.

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A CASE OF CONGENITAL NÆVUS LIPOMATODES.

BY

JAMES NEVINS HYDE,

Chicago.

ON the 3d of October, 1883, P. F., æt. 3 years, was brought to me by his parents, each of whom presented the usual appearance of sound health. The father was forty-eight years old, and gave no history of illness save that, a few years before, he had suffered from a mild attack of rheumatism. The mother, forty-one years old, stated that she had always been well. Of their four children, two besides the one whose case is here reported were then living. All were physically perfect and in sound health. One child had died in infancy of a disorder which they could not definitely describe. The family history was minutely investigated as far as the paternal and maternal grandparents of the child, its uncles and aunts on both sides, and the children born to one sister of the mother. In none were there traces of disease or of deformity.

As may be generally expected in such cases, there was, in the present instance, a history of ante-natal maternal impression. The mother said that early in the pregnancy which resulted in the birth of this child, she had been "kicked by a cow." She referred the deformity of her infant to this accident alone. The child had been, when it first came into the world, deformed, and in very nearly the condition presented at the date of the examination, the only difference to be recognized depending upon the slight deepening in the shade of color of the pigmented patches, the increase in the pilary growth, and the development of the tumors as the body of the child increased in size.

the other on the dorsal surface of the trunk, and reaching from the second dorsal to the last lumbar vertebra.

Cases of unusual multiplicity of pigmented moles have been also observed by 'T. De Amicis' and by myself,² the moles in the last-mentioned case having been curiously arranged upon one side of the body only, in the lines commonly traced by the lesions of zoster affecting the same regions.

Geber³ reports a case where yellowish-brown and roundish spots were seen also upon the scalp.

Paget⁴ records the case of a girl, 12 years of age, whose mother, at some time during the pregnancy preceding her birth, was frightened by a monkey attached to a street hand-organ. In this case, the left upper extremity and the greater part of the same side of the trunk and neck of the child were deeply stained and covered with long harsh hairs, from one to two inches in length.

Still rarer are the mollusciform or lipomatous nævi. Damon in his treatise⁵ does not seem to have known of the more extensive forms of this growth, as his description applies to the smaller varieties only; and several dermatological authors are equally silent as to the possibilities of development in this deformity. Neumann, for example, speaks of the larger lesions as attaining the size of the fist.

Italian observers seem, curiously enough, to have had a more fertile field for observations of this kind. Perhaps the darker race, to which in great part their observations must have been limited, may be allowed to explain the fact. Manassei,⁶ for example, gives an illustration of the back of a female child, covered from the scapulæ to the thighs behind, and from the umbilicus to the same general line anteriorly, with an extensive, brownish and blackish, pigmented mole, covered with hairs. Here and there, over the surface thus involved, were nut-sized lipomatous tubercles. The arms and legs below the cuirass-like mole had bands of similar pigmentations covered with hairs and tuberosities; while smaller pigmentations, circumscribed and roundish, as in the case here illustrated, were sprinkled irregularly over the general surface of the skin.

But certainly most interesting in this connection, Angelo Scarenzio,⁷

¹ *Lo Sperimentale*, Mar., 1876.

² *Chicago Med. Jour. and Exam.*, Oct., 1877.

³ "Ueber eine Selten. Form von Nævi der Autoren," *Viertel. für Derm. u. Syph.*, 1874.

⁴ *Lancet* for 1868; see the *Jour. of Cutan. Med.*, vol. i., 1868, p. 471, observation reported by Smith.

⁵ "Structural Lesions of the Skin," *Phil.*, 1869.

⁶ *Giorn. Ital. d. Malatt. Vener. e. d. Pelle*, 1877, p. 227, "Su di un Caso di Nèò Verrucoso, Pigmentario, Peloso, Congenito."

⁷ *Giorn. Ital. d. Malatt. Vener. e. d. Pelle*, 1877, p. 220, "Di una Singolare Alterazione Pigmentaria, Verrucosa, e Lipomatosa Congenita."

reported an observation of his, to the Royal Institute of Science and Letters in Lombardy, which in many points resembles the features of the case here described. The resemblance is so great that the illustration accompanying his printed report might almost serve as a representation of the child under my observation, after the attainment in the



future of adult years. It is in consequence of this resemblance, and of the practical fact thus suggested, that I have reproduced the cut from the author's original paper. It indicates with sufficient clearness, without a reproduction of the written details of the case, the extent and character of the deformity.

The age of the subject is not given, but it is stated that he was one of a family of eight children, none of whom was similarly disfigured. The

mother, being interrogated, could offer no explanation of the result, save that when pregnant before the birth of this child, she had been greatly disturbed when in the market-place, by her husband not consenting to humor one of her wishes. Frassini, for that was the name of the subject of the sketch, had attained adult years, and presented himself for examination merely to secure exemption from military service. It will be seen that the shoulders are covered with roundish discrete maculations; these also covered the face, and were, at his time of life, tawny-colored and blackish, covered with hairs, and in this region numerous. The gigantic mole figured in the illustration was brownish-black in hue, beginning, above, at about the same point as in my case, and with equally symmetrical curves reaching below the umbilicus in front. The line of demarcation on the left thigh was distinct; irregular below on the right; and the lipomatous growth, lobulated and pendulous, reached in this case also over the right loin and buttock. Pigmented moles, moreover, were visible on the legs below the knees. Scarenzio also discovered two upon the glans penis, in close proximity to the urethra.

These two figures tell their own story, and tell it very plainly. An Italian woman brings into the world a child marked by a rare congenital deformity that is almost reproduced in fac-simile, after nearly a score of years have elapsed, in the child of a woman of German descent, whose pregnancy was conducted and concluded in a distant continent, with a totally different environment. The possibility that peculiarities in the character or circumstances of an impression, made upon the pregnant woman and conveyed to her unborn child, determine the nature of any deformity subsequently apparent in the latter is thus dispelled. The several animals, monkeys, cats, dogs, cows, bats, etc., that have been described as influencing the shade of color, degree of hairiness, and surface arrangement of these moles have evidently no relation whatever with the results. It is probable that the nervous centres of the new being, and of none other, have immediate control over these rare consequences. What influences may be transmitted to such centres, through the umbilical cord, or, at an earlier period of gestation, through the more intimate connection existing between the ovum and the mother, must at present lie in a field where conjecture alone is possible.

It is the part of science, however, to record with distinctness that nature, even in what appears to be her wildest aberrations, obeys a law which is not less appreciable than those in accordance with which she constructs the fabric of life in both the vegetable and animal creation. It is, indeed, in the strength of convictions thus produced, that the patient student of those laws is enabled to follow with safety and satisfaction the paths in which her footsteps can be traced.

DERMATOLOGICAL NOTES.

BY

ROBERT B. MORISON, M.D.,
Baltimore.ELEPHANTIASIS OF THE FOREARM.—PRURIGO.—DERMATITIS VENE-
NATA.—ERYTHEMA URTICANS.—UNNA'S PREPARATIONS.

IN the Dermatological Notes of the May number, Dr. Fox relates a case of "Elephantiasis of the Forearm and Hand." Such cases are rare, but Dr. F.'s case is not the first one reported in this country. In the *Maryland Medical Journal*, Feb. 21, 1885, will be found the history of a case of E. Arabum of the left forearm and hand which came under my treatment more than a year ago. A brief outline of the case may be worth reprinting.

Mr. —, æt. 50, married, a man of the most generous habits of life, who confessed to a chancre dating ten years back, showed me his left hand. It was puffy, the fingers and back of the hand having a flabby, doughy appearance, evidently the result of previous inflammation. The arm above the wrist, and half-way up to the elbow, was more tensely swollen than the hand. No hard knots or swollen glands could be felt in the skin, but the glandulæ cubitales, as well as the glandulæ axillares, were decidedly enlarged. Both palms were sprinkled over with large and small, round, flattened, brownish-red spots which were evidently specific in character. There was no difficulty in making a diagnosis of psoriasis palmaris syphilitica.

Many years ago, the patient was shipwrecked on a rocky coast, was left for many hours in the water clinging to ropes and rocks, and was rescued with his hands and feet frost-bitten. Since this unlucky accident, these members have been subject to repeated attacks of eczema (?), which would disappear, leaving only the spots upon the palms. The left hand and arm have been subject to recurrent erysipelas, and after each attack the chronic swelling of the limb was slightly more pronounced. A diagnosis of E. Arabum was made, but, contrary to what the patient had been told, its etiology was explained to be syphilis and not frost-bite. He was put upon hypodermic injections of Liebreich's one-per-cent solution of hydrargyrum formamidatum, fifteen minims once a day, for twenty days. At the end of this series of injections, the psoriasis had entirely disappeared. The hands then presented a normal appearance, as far as any frost-bite was concerned, and the œdema of the arm and back of the left hand had decreased one-half. Subsequently I watched the patient through an acute attack of erysipelas of the left arm, similar, he

said, to all previous ones, excepting that it was more severe than usual. He is now attending to his accustomed duties, but his left hand and arm are noticeably larger than the other, and while a moderate abstinence from strong drink—total abstinence (from long indulgence) being out of the question—has put him in better health, yet the *locus minoris resistentiæ* still remains awaiting an exciting cause for just such another attack to increase it.

Prurigo.

After having made a special study of prurigo, both macroscopically and microscopically, in Vienna and Prague (vide *American Journal Medical Sciences*, October, 1883), it was with a great deal of interest that I returned to America, thinking to investigate why the disease was so seldom reported in this country. I had been told on the other side—and it is hinted at in various German authors, *e. g.*, Auspitz, Kaposi, Pick, et al.—that it was probably due to the fact that the disease was not recognized in America. So I have been hunting for two years like Diogenes among the patients of a large clinic for an honest case of prurigo. In all this time I have only seen one case of prurigo simplex. It was that of a young man, æt. 23, born of German parents in this country, who never remembered the time when he did not have to scratch himself, night and day, upon his legs, arms, and abdomen. The skin of the extensor surfaces of the arms and legs, as well as that of the abdomen, was parchment-like, dirty-brown in color, slightly excoriated in places, with many isolated small papules scattered about, which were more perceptible to the touch than to sight. The skin felt, when the fingers were passed over it, as if a fine nutmeg grater had been placed underneath it. The glands of the groins, as well as in other places, were enlarged. The diagnosis seemed to admit of no doubt from the situation of the disease, the usual prurigo history, and its general appearance. The man in other respects was perfectly healthy and well developed. The disease worried him more because his fellow-workmen ridiculed his scratching than because the act of scratching was necessary. After coming twice to the dispensary he appeared no more. My assistant, Dr. Keyser, kindly hunted him up, and he was to have been presented to a medical society, but when the time came, he failed us.

Dermatitis Venenata.

I should like to call the attention of dermatologists, especially at this season of the year, to the results obtained in this class of diseases from the use of Prof. Pick's 5% salicylic acid gelatin. The relief to the burning and itching has been almost immediate, and the disease, in all the cases upon which it was tried last year, disappeared after a few days' applica-

tion. It would be interesting to hear the experience of others after trying this remedy upon such cases.

Erythema Urticans.

The dermatologist is not often asked to attend a so-called "urgency" case. The following is an exception, however. Some time ago, a physician drove me hurriedly to see a man who, for the better part of two nights and days, had been walking his room with nothing on but his shirt. So great was the ever increasing itching on his legs he could not keep still, and it was with the greatest possible effort that he kept from tearing the skin from them.

I found upon them, extending from the junction of the legs with the abdomen nearly to the knees and half-way round the inside of the thighs, two very red, blotchy-looking spots with no papules, vesicles, or pustules. The line of demarcation was distinct and in some parts of it was slightly raised. The patient said it had commenced in smaller spots separated from each other, but which had quickly spread until they covered the spaces already described. Eczema of any form was excluded, and I had evidently to do with an aggravated case of urticaria, for which I could think of no better name than the one given above.

It is difficult to imagine the utter demoralization of this poor fellow. He had only found relief from hypodermic injections of morphia. Having taken with me a piece of Pick's 5% salicylic acid gelatin, it was melted in a saucer over hot water and applied with a brush over the whole surface of the affected parts. A small amount of glycerin was rubbed over it when the gelatin had sufficiently hardened. The relief was immediate. The patient slept well during the night and was in his office the next day. The application inconvenienced him slightly, as the gelatin gave him a feeling of contraction upon his legs, but it was nevertheless continued for two days and nights, by which time the irritation had so much subsided that it was discontinued. He has had several similar attacks during the last year, but he is never without his gelatin which he now mixes and spreads for himself, and he has so far been able to control a fresh attack as soon as it appears. An interesting point in the etiology of this case is that the patient finds, if he indulges in the good things of this world to any extent, especially if they be moistened with several drinks of whiskey, he is almost sure to have an attack. He thinks, however, it is the drink and not the food which brings it on, for he has noticed the same result after taking two or three drinks of whiskey without any food. He certainly has had greater immunity from attacks since giving it up.

Prof. Unna's Preparations.

It is surprising that Unna's preparations are not better known in this country.

They have proved themselves in my practice to be useful in a high degree, and I know at present nothing which takes their place. Skin therapeutics has for so long a time consisted of local applications, uncomfortable to the patient, unclean to the clothes, and unsatisfactory to the physician, that any improvement on the old-style treatment should be received with favor. Unna's plasters are simple, clean, comfortable, and efficacious. Their expense has been the only drawback to their introduction into America; our duties raising their first cost beyond the pockets of the masses. This defect will, I hope, however, soon be remedied by their manufacture in this country, and they will then be fully appreciated. Histories of several cases in which they have been used by me can be found in a recent number of the *Deutsche Medicinische Wochenschrift* (Berlin), and *The Medical News* (Philadelphia).

DOUBLE GUMMA OF IRIS, AND ITS EARLY MANIFESTATION (WITH
ILLUSTRATION).

BY

EDWARD S. PECK, M.D.,

Ophthalmic Surgeon to St. Elizabeth's Hospital; Visiting Surgeon to Charity Hospital, New York.

THE notes of the following case of double gumma of the iris were kindly prepared by Dr. Andrew Manning, House Surgeon of the Ophthalmic Division of Charity Hospital. They are of interest, first, on account of the comparative rarity of biniridal gummata; and secondly, on account of their early manifestation, viz., five months after the appearance of the chancre.

J. M., male, aged 23 years; single, laborer, born in the United States, was admitted to ward 13 (Venereal Division), March 6, 1885, with a pustular syphilide attended with crusts, thickly covering the face, arms, and legs, very slightly appearing on the trunk. Initial lesion developed on the foreskin five months before, and thirteen days after vicious connection. Patient at the above date had become so much emaciated as to have weighed about one hundred pounds. He was admitted to the eye-ward late in April, the affection of the eye dating from about April 15. On admission, both eyes presented the usual symptoms of syphilitic inflammation of the iris, viz., lachrymation, photophobia, pinkish zone of

injection around the cornea, opaque anterior chamber, muddy and nodular anterior surface of iris; both eyes and brows were exceedingly painful. Gumma of right iris springs from its lower limb, completely fills the corresponding area of the anterior chamber, and lies in contact with the posterior surface of the cornea; its breadth at base measures one-eighth of an inch. It preceded the development of the left gumma by two days. The latter growth is situated on the outer and upper segment of iris, and invades the pupillary field more than the right one. Under



atropine, the left pupil dilates in the shape of a kidney placed in a vertical position, while the dilatation of the right pupil is but little interfered with. Vision of the right eye is noted "good," while the left eye counts fingers at only five feet.

Patient was treated with a formula of mercurial biniodide gr. $\frac{1}{32}$; potassium iodide, gr. v.; and compound syrup of sarsaparilla, three times a day; locally with atropine solution, gr. iv. ad ζ i., and a collyrium of boracic acid in saturated solution (about four per centum). In addition, patient received a warm bath every second day. Under this treatment, the eruption has already materially faded away, the inflammatory symptoms have abated, and the gummata are being rapidly absorbed. At this date, one of the growths has nearly disappeared, the patient having been but one month under specific treatment.

NEW YORK, May 13, 1885.

VERATRIN IN PRURITUS.—In pruritus occurring about the time of the menopause, Chéron (*Gaz. des Sciences Méd.*, Sept. 27, 1884) recommends the use of veratrin, internally and externally, giving from two to six pills daily, each containing $\frac{1}{120}$ grain. Externally he uses an ointment containing from two to three grains of veratrin to the ounce of simple ointment.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

155TH REGULAR MEETING, MAY 26, 1885.

ANNUAL MEETING.

DR. A. R. ROBINSON, *President, in the Chair.*

DR. BULKLEY presented a case of

LUPUS VULGARIS.

Jennie S., aged 13 years; Hungarian. The eruption first made its appearance three years ago. Now there are characteristic pulpy and tubercular patches of lupus situated on the ears, cheeks, chin, neck, both arms, and buttocks. In some places there is loss of tissue.

The case was shown because of the multiplicity of the separate lesions, there being at least twenty, and also because of their symmetrical arrangement. In many respects, there were points of resemblance to scrofuloderma.

Dr. Bulkley wished to know if any of the members had observed a case of lupus in which there were so many scattered lesions. He had never before seen a case in which there were more than half a dozen isolated patches.

DR. PIFFARD said that he had seen a case of lupus erythematosus in which he recorded about thirty or forty separate lesions as being present.

DR. FOX spoke of some cases of lupus vulgaris that had been presented before the Society, where the hands were affected, and in whom there were many isolated patches. In the cases referred to, it was difficult to distinguish between lupus and scrofuloderma. He had, however, never seen a well-marked case in which the patches were so numerous as in the one shown to-night.

DR. BULKLEY then showed a case of

PITYRIASIS ROSEA (PITYRIASIS MACULATA ET CIRCINATA).

Maggie H., single; 22 years old. Hat trimmer. Her general health has never been very good, being subject to attacks of dizziness and suffering from dyspnoea upon exertion, as well as palpitation at times. Bowels inclined to be constipated. Menses very irregular. There is a tendency to varicosity of the veins.

About three weeks ago, she had intense pruritus of the chest which lasted several hours, when an eruption was discovered, consisting of several bright-red spots, each the size of a ten-cent piece, scattered over the chest. The lesion spread rapidly over the breasts and into the axillæ, and has been gradually extending since.

The eruption now covers a large area, reaching above nearly to the clavicles, covering the breasts, and extending below to the ensiform cartilage, and laterally nearly to the hips. It also extends on each side into the axillæ, where it is most deeply colored; the scapular region is also affected. There is no eruption in the interscapular space, nor in the upper or lower extremities. When the eruption first made its appearance, it was of a bright-red hue. Now, in front and behind, it is a pale, dingy red or yellowish color.

The lesion is composed of separate centres of inflammation, varying in size from a pin's point up to one or one and a half inches in diameter. The circumference of each separate lesion is irregular in outline, the margins being distinct,

except where the patches have coalesced, which is of frequent occurrence. The centre of each of the patches is of a dull whitish yellow, less vivid and depressed as compared with the circumferences. There is, or has been, more or less scaling over each patch. The scales are thickest at the middle, are not easily removed, and at present are most marked about the axillary regions. When a scale is removed, several slight cicatrices remain. Besides the circinate spots, papules and macules are also present. The severe irritation has been confined mostly to the axillary regions.

The patient was sleeping alone when the eruption appeared. Immediately after its appearance she slept with an aunt, who developed a slight itchy eruption on the chest; it remained but a few days, and differed from that seen in the patient.

DR. FOX believed the case to be an excellent example of that rare disease—pityriasis maculata et circinata. He thought many cases of seborrhœa sicca had been described under the name of this disease. He said that the lesion bore many points of resemblance to erythema multiforme, especially in the multiplicity of the lesions.

DR. ROBINSON had seen three cases, one of which was doubtful, because of the marked seborrhœa of the scalp and sternum. Another of the cases was scaly and covered a greater area than the case under consideration. The lesion disappeared in about three months, the treatment being applications of green soap.

DR. BULKLEY remembered having seen two or three cases. One was a most superb case, and occurred in an attendant on a Turkish bath, and disappeared in six weeks under treatment. In another patient, the eruption remained a long time, and finally disappeared slowly.

DR. FOX mentioned the case of a lady who had pityriasis rosea, occupying the trunk and upper and lower extremities. Local remedies were used for three or four weeks with no apparent effect, when quinine was given internally, causing the lesions to disappear in a few days.

DR. BULKLEY presented a

CASE FOR DIAGNOSIS.

He believed it to be one of scrofuloderma papulatum, but at times during the treatment the question occurred to him whether it might not be a case of acne cachecticorum. He would like to have an expression of opinion from the members as to the diagnosis.

Mrs. J. H., 30 years old, married. About seven years ago, she had an ulcer of the throat, which left a scar; this was probably a scrofuloderm. There is no history of syphilis. The teeth are normal. Five years ago, an eruption made its appearance on the back of the neck and shoulders, and has been worse for the past year.

Now on the forehead as far as the hairy scalp, on the cheeks, chin, back and sides of the neck, also slightly on the arms, are maculo-papules of a dull red color, not paling on pressure. These papules are discrete, not very numerous, are covered with a scale, and vary from a pin's head to a pea in size. There is not much tendency to pus formation. The face is slightly oily, and there are a few comedones as well as some acne rosacea. There are many brownish discolorations, and white scars are to be seen where papules formerly existed. Many of the papules have had their summits scratched off. Some of the papules have remained at least six months before disappearing.

DR. BULKLEY next presented a case of

SCROFULODERMA PUSTULOSUM.

A. McC., 36 years old, liquor dealer, denies ever having had venereal disease. He was married when twenty-two years of age, and is the father of four chil-

dren, viz., a girl, 13 years; a boy, 12; a child who was killed accidentally, and a boy, 9. All of his children are healthy, and have had no skin lesions. His wife is healthy, has had no miscarriages, and no eruption. His sister is living and in good health. His father died at 63, and his mother aged 55. They were both free from eruption.

Ten years ago, the patient first noticed an eruption on the back of the fingers, said to resemble that with which he is now affected, and at the time it was supposed that it was occasioned by his occupation as bartender. About six years ago, the lesion first made its appearance on the body. He has never been free from eruption during the past ten years: about five years ago it was at its worst.

At the time, four years ago, when the patient was shown to the Society before, the whole of the body, limbs, hands, feet, neck, chin, and nose, were the seat of an eruption, as follows: On the hands were some deep-seated vesicles; on the palms and some of the fingers were hard masses with surrounding inflammatory areolæ, these masses being about half an inch in diameter. On the back of the elbows were masses of cicatricial tissue and new inflammatory lumps, having very much the appearance seen in syphilis. One hard infiltrated mass was to be seen on the end of the nose. Between the toes of both feet were inflamed masses, resembling mucous patches.

At the time the case was shown before, it was believed to be hydroa, but on further study, Dr. B. has come to the conclusion that it is a scrofuloderma. Now there are several hard lumps and masses on the hands, feet, and extremities. All over the body, buttocks, legs, and arms are marks of scarring, and many cicatrices. In the last four years the eruption has improved, and the patient is in much better health than since the appearance of the lesion.

DR. BULKLEY afterward showed a case of

SCROFULODERMA.

A. H., aged 16 years. When 6 years old, a swelling began on the right side of the neck, and was thought to be mumps. He had been in good health previously, with the exception of having had a slight attack of measles a year before. The mass on the neck broke, and has never healed up since. Six months later he began to have abscesses about the left hip, and was in the Hospital for Ruptured and Crippled for two years.

Since the beginning of the disease, he has had a series of ulcerations about the neck, and on the thighs and hips, the scars of which are present in abundance. There are many open ulcers at present.

DR. FOX believed the first case to be a form of acne, the second and third cases were, in his opinion, scrofulodermata. Referring to the first case, he said that he had seen a case of acne of the back in a woman, in whom there were no signs of eruption elsewhere, and no pustulation, and the patient said that some of the papules had remained six months at least.

DR. SHERWELL would call the first case a lupoid acne. The second and third cases were typical scrofulodermata.

DR. PIFFARD said that there was no question in his mind as to the diagnosis of the second case, viz., scrofuloderma.

DR. BRONSON would call the first case an acne, but differing from an ordinary acne in almost an entire absence of comedones. In this case, there was a certain amount of desquamation of tissue leaving a scar, and constituting the lesion called lupoid acne. In regard to the second case, he had never seen a parallel to it: it was either syphilis or scrofuloderma. His idea was that persons affected with scrofuloderma were profoundly scrofulous, which was not the case in this instance.

DR. ROBINSON believed the first case to be an acne, and said that it reminded him of a case of a woman, 25 years old, who had a similar lesion lasting four years, and during all of that time she did not menstruate. He considered the first case to be a similar one; it was a serous inflammation of the follicles. He did not think that he had ever seen a case where a single lesion lasted six months.

DR. BULKLEY said that he had watched the case closely for nearly a year, and had noted separate lesions lasting for many months. Dr. Elliott had examined a specimen taken from the breast, but with only negative results.

ADULTERATION OF DRUGS.

DR. PIFFARD said that for some time he had found that chrysarobin did not produce the same results as formerly, and that it was comparatively inert.

DR. FOX and other members said that they had the same experience.

DR. BULKLEY then read a paper on

SCROFULODERMA.

An election of officers for the ensuing year was then held, when the following were elected: Dr. W. T. Alexander, President; Dr. E. B. Bronson, Treasurer; and Dr. A. R. Robinson, Geo. H. Fox, and P. A. Morrow, Executive Committee. Under the by-laws, Dr. Robert Campbell remains Secretary until October, when Dr. D. Lewis succeeds to the office.

The Society then adjourned until the fourth Tuesday in September.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

(From our Special Correspondent.)

PROFESSIONAL DERMATITIS, ECZEMA OF SPINNERS AND WEAVERS OF FLAX—NATURE AND PATHOLOGICAL ANATOMY OF ERYTHEMAS, OF POLYMORPHOUS ERYTHEMA IN PARTICULAR—BACILLI OF RHINOSCLEROMA—LUPUS AND TUBERCULOSIS—TREATMENT OF LUPUS.

PROFESSOR LOLOIR has observed in his clinic of cutaneous and syphilitic diseases at the Hospital St. Sauveur, of Lille, in 1884 and 1885, a disease of the skin as yet not studied, and peculiar to spinners of flax. This affection is situated upon the hands, and is symmetrical, though the left hand is more often attacked than the right; the internal surface of the thumb, the external and palmar surface of the index, the cubital and palmar border of the hand and of the little finger are the parts most affected. In some cases, the hands and the fingers may be invaded in their entire extent. It is an eczematous dermatitis; it may take on several types; it is sometimes an erythemato-vesicular eczema, more or less confluent; it is sometimes a vesiculo-pustular, sometimes a squamous eczema; it may be a dry lichenoid eczema, with thickening of the derma and fissures of the epidermis, the horny layer of which takes on at certain points a notable development. Pruritus is constant, but quite variable in intensity; there exist certain functional troubles, such as stiffness of the hand and fingers. This affection is peculiar to artisans who work in the flax when wet, and is due to the prolonged

action upon the hands of a hot, viscid water charged with impurities removed from the flax, and containing a quantity of salts of lime much less than that existing in natural water—all conditions which facilitate maceration of the epidermis.

The treatment of this affection, when once developed, consists in the suspension of the work and the application of the means used in ordinary eczema. As to prophylaxis, it will be found of advantage to renew the water as often as possible, and to add to it the lime-salts lacking. The workers should smear their hands with glycerin during their work, and carefully wash them when they have finished.

Nature and Pathological Anatomy of Erythemas, of Polymorphous Erythema in Particular.—The same author has just published very interesting researches upon the nature and pathological anatomy of erythemas and of erythema multiforme in particular. He has studied the diverse stadia of this last affection, as exhibited in fragments of skin obtained from a number of patients during life.

1st. The simple redness is characterized, histologically, by a dilatation of the vessels of the derma, especially at the level of the *pars papillaris*, and by a slight diapedesis of the white globules.

2d. When the redness is accompanied with a certain degree of thickening of the skin, the dilated vessels are surrounded by veritable muffs of extravasated lymphatic cells, and are engorged with red globules. There is at the same time extravasation of certain red globules, and a quantity of sanguineous serum colored red by the hæmoglobin.

3d. When the process arrives at the formation of papules, there is a considerable exudative hyperæmia of the derma, and even of the hypodermis which remains intact in the preceding forms; in addition, there exists quite frequently a dilatation of the nucleoli of a certain number of the cells of the Malpighian layer, which may sometimes even prevent signs of a cavernous alteration; there is also found a considerable number of migratory cells in the deep layers of the epidermis.

When the erythema takes on a hemorrhagic aspect, the diapedesis of red globules becomes considerable. There may also be seen in the sections a large number of dilated lymphatic spaces, very rarely containing fibrin.

4th. In the papulo-tubercular erythema or erythema tuberosum, the hypodermis is invaded in a much more marked manner; the cells of the connective tissue tend to proliferate, and the exuded liquid often contains fibrin; nevertheless the phenomena of exudative hyperæmia or congestive œdema predominate; the diapedesis of red globules in this last form is generally very abundant.

5th. In the case of bullous or pemphigoid erythema, the histological examination shows: *a*, in a primary degree, when there are not yet phlyctenulæ visible to the eye, the Malpighian body is invaded by a large number of migratory cells, and there exists at certain points of the epidermis the beginning of a cavernous alteration. At the summit of the papillæ, one may observe that the cylindrical cells of the perpendicular layer are detached *en masse* in places corresponding to the extent of about ten cells and constituting thus a sort of minute deep phlyctenule, the cavity of which is filled with a slightly fibrinous exudation containing leucocytes; *b*, in the second stage, a superficial phlyctenule is formed, which is limited above by the horny epidermis with some portions of the stratum lucidum, beneath by the granular zone and the remainder of the stratum lucidum.

The liquid of the bulla contains only a few traces of fibrin and occasional leucocytes. Prof. Leloir then enters into some very interesting pathogenic considerations upon the mode of production of these lesions and the purulent transformation of the phlyctenulæ. Our space forbids us entering into all the details. The conclusion of the author is that, until we are more amply informed, we must still consider multifiform erythema as an angioneurosis, the cause of which may be very diverse and multiplied.

Bacilli of Rhinoscleroma.—MM. Cornil and Alvarez have submitted to the Academy of Medicine of Paris, March 31, 1885, a most important communication upon Rhinoscleroma. This rare cutaneous affection, which consists of a thickening under the form of plaques and tumors of the nasal septum, the upper lip, the nostrils, the nasal fossæ, sometimes even the lower lip, the pharynx, and the larynx, has been until now especially studied only by Hebra and Kaposi, of Vienna. The patients upon whom Prof. Cornil made his investigations were from Central America. In the first examination, made some two years ago, Prof. Cornil did not observe the parasites of rhinoscleroma, although Frisch, Pellizari, Chiari, and other histologists had demonstrated their existence. A modification in his technique enabled the French observer to discover them; he has since found them in all his examinations and gives the following description: they consist of short rods from $2\frac{1}{2}$ to 3 millimetres in length, and from 4 to 5 tenths of a millimetre in width. This rod presents granules highly colored which resemble spores; the border of the rod slightly exceeds the granules. In coloring the sections for forty-eight hours in a $2\frac{1}{2}$ per cent solution of violet C. B. and in decolorizing them for forty-eight hours in absolute alcohol, the microbes are observed "presenting quite regular ovoid forms, the periphery of which is formed by a transparent hyaline substance, lightly colored in blue violet, and containing the rod encapsuled. At the centre of this capsule is found the rod which is sometimes homogeneous and smooth and strongly colored, sometimes in the form of two, three, or four round or ovoid granules likewise quite pronounced in color. Around the rod there is always a clear line. Many of the encapsuled rods are free in the tissue of rhinoscleroma, between the fibrilla of the pars reticularis, around the large cells, and in the lymphatic vessels, both in the superficial and deep portion of the derma."

According to these researches, it is evident that rhinoscleroma should be classed among the parasitic affections, producing tumors, like tubercular leprosy, perhaps like actinomycosis. Still it is well to not be too hasty in generalizing: it is to be hoped that cultures and inoculations will soon elucidate all the facts so important from a clinical, a therapeutical, and especially a prophylactic point of view.

Lupus Tuberculosis, Treatment of Lupus.—I have endeavored to keep the readers of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES posted in regard to the numerous works published in France for some time past upon the nature of lupus. They are doubtless familiar with the celebrated discussion which took place at the Congress of Copenhagen, and it is quite useless for me to give an analysis of the interesting communications of Prof. Leloir and Dr. Barthélemy. Prof. Besnier has recently broached this question anew with his recognized ability and great authority. This eminent author has, by his lectures, his writings, his clinical researches, and the numerous works which he has inspired, contributed, more than all others, to the elucidation of the relations between lupus and tuberculosis. Profoundly con-

vinced of the tuberculous nature of lupus, M. Besnier has since 1880 taught that lupus is always a scrofuloderma. He has since elaborated his opinions and published his new method of treatment by igneous scarifications. (V. JOURNAL CUTANEOUS AND VENEREAL DISEASES, March, 1884, p. 84.)

In a new communication appearing in the *Annales de Dermatologie et de Syphiligraphie*, Jan., 1885, he reviews the progress which his opinion has made in this brief period, and he endeavors to convert to his view certain opponents who remain, by discussing with the greatest precision the points in litigation. These points are the following. 1st. Nosographical unity of lupus. 2d. Nosological unity. 3d. Relations of lupus with tuberculosis. 4th. Present condition of the therapeutics of lupus.

The nosographical unity of lupus is regarded as indisputable by M. Besnier; perhaps there may be certain forms of syphilis, of leprosy, or of scleroderma which are difficult at first to diagnosticate from lupus; but according to him the existence of a syphilitic lupus should not be admitted. The lupoid lesion is either lupus or syphilis, acquired or hereditary; there is no mixed variety. It sometimes seems that hereditary syphilis may be in certain cases a predisposing cause to the development of cutaneous lesions identical in aspect with lupus—lesions which in some instances are cured by anti-syphilitic treatment. We have often heard our distinguished Prof. Fournier declare that one should divide the profound dermatoses, formerly described under the name of lupus, into two categories; *a*, syphilides, most often hereditary; *b*, tuberculosis.

M. Besnier also remarks that there are certain marked or irregular forms of lupus erythematosus of the face and extremities which might easily be confounded with certain varieties of erosive or atrophic acne, and inversely. In every case, says he, these difficulties depend upon the imperfection of our knowledge and they do not in any manner imply the fundamental reality of a radical dissimilarity between several distinct diseases which might be confounded with that which at the present time it is found convenient to denominate lupus. 2d and 3d. The nosological unity of lupus is at present demonstrated according to M. Besnier: "The different lupuses are only species, forms, varieties of a single and unique pathological genus." "the clinic, histology, and experimentation have proven in the most irrefutable manner that they are only different aspects of cutaneous tuberculosis."

The dissimilarity which exists between lupus of the skin and mucous membranes on the one hand, and lesions of the same part, hitherto termed tubercular, on the other—a dissimilarity most marked and striking—does not constitute for him an argument in favor of the non-identity of lupus and tuberculosis, for "just as the dermatopathies of secondary syphilis differ from those of tertiary syphilis, so primary tuberculosis of the skin (lupus) has not the characters of infectious or tertiary tuberculosis, which alone manifests itself upon the skin or mucous membranes by granulations or typical ulcerations termed tubercular. Of these two lesions, the one is an external, local lesion, evolving for a long time locally upon a non-infected patient, the other is a manifestation of an accomplished general infection." 4th. Dr. Besnier is always faithful in principle to the general treatment of lupus by the method of scarifications and igneous cauterizations with the galvano-cautery—a method which I have described in one of my previous letters; but he has quite recently experimented in his service with another procedure which has given quite good results in cases of very old and extensive lupus with mutilation. It consists in painting the lupus surfaces with a piece of char-

pie dipped in a maximum solution of pyrogallic acid in ether, or in spraying them with this solution. The diseased surfaces become instantly covered with a white and adherent layer of pyrogallic acid; this layer is then covered with a protective coating of traumaticine. The next few days it produces an irritation analogous to that of a strong vesicatory : but this irritation is limited almost exclusively to the diseased tissues. This is repeated until the complete disappearance of every active lupic element ; the consecutive cicatrix is smooth. This method, which is derived from that of Schwimmer, is especially suited for timid patients and in cases of common tubercular lupus ; it does not succeed so well in lupus erythematosus, for which the interstitial electro-cauterization is, according to M. Besnier, *the therapeutic method par excellence*.

In terminating this analysis, I regret to add that the ideas just enunciated are far from being admitted by all French dermatologists, by Dr. Vidal in particular. He does not believe in the tuberculous nature of the typical lupus of Willan, of sclerous lupus, and still less of lupus erythematosus. He continues to treat the different varieties of lupus by his method of quadrillated linear scarifications—a method which he modifies according to the indications of different cases and which gives him most excellent local results, without in any way interfering with the general health of his patients.

Dr. L. BROcq.

PARIS, May 15, 1885.

Selections.

ODORS OF THE SKIN AND ITS APPENDAGES.

THE perspiration and the various cutaneous secretions impart a peculiar odor to every human being, as well as to each of the inferior species. This physical characteristic, of which, in general, we are hardly aware, is very acutely perceived by those persons in whom the olfactory sense is exceptionally developed. It is well known that many savages, as Indians, negroes, etc., can smell each other at long distances, just as a hound follows up his master by the scent. Individual instances of a similar character, but much more extraordinary, are not unknown in civilized society. Thus, Cadet de Gassicourt, in the *Dictionnaire des Sc. Méd.*, speaks of a young lady who could distinguish men from women simply by their odors, and who could not endure the smell of her bedclothes after any one else had handled them. In the *Journal des Savants* for 1684, we read of a Hungarian monk who was able to decide in the same way upon the chastity of females. The thing is not so very wonderful; we ourselves are acquainted with a physician who makes a specialty of diseases of women, and whose nose informs him with unfailing accuracy whenever a patient is menstruating. The odor of the skin is rarely a pleasant one. Alexander the Great, according to Plutarch, exhaled the perfume of violets when he perspired, and in modern times, Malherbe, Cujas, and Haller are said to have diffused an agreeable odor of musk. In ordinary individuals, the cutaneous odor is sulphurous and somewhat repulsive. Old Ambrose Paré observes that this is especially noticeable in the red-haired and freckled. Dark-complexioned persons smell of prussic acid; blonds, much more feebly, of musk. Fat persons are more odorous

than lean ones; the former frequently have an oily smell, due to an excessive formation of fatty acids in the sebaceous secretion.

Age exerts a considerable influence on the cutaneous odor. Nursing infants have a peculiar sourish smell, caused by the butyric acid in their milk. Bottle-fed children smell of strong butter, cow's milk being so much richer than woman's in the oily principle. After weaning, a baby's odor becomes less decided, and, it is said, more agreeable. The human male, at the period of puberty, exhales a characteristic odor which, though less pronounced, is similar to that of an animal in heat. This odor, which is one of the leading symptoms of what Bordeu calls the *seminal fever*, is more strongly marked in those who are continent. It is probably caused by the absorption of the spermatic fluid into the circulation and the elimination of its odorous principles through the skin. At all events, it is certain that it disappears as soon as the reproductive organs become enfeebled. In old age the skin exhales an odor which has been compared (without any metaphorical intention) to that of *dry leaves*. It is possible, therefore, to tell, by the sense of smell alone, if not the exact age of a person, at least the period of life at which he has arrived.

The influence of race upon the cutaneous odor, though perhaps less familiar, is quite as indisputable. The inhabitants of southern latitudes do not smell like those of the north. Their cutaneous functions are more actively performed. "The human flower," to use an expression of Goethe's, like the products of vegetation, is more highly perfumed in warm climates. This is especially evident in negroes, whose rank, ammoniacal odor, unmitigated by cleanliness, is attributed by Pruner-Bey to a volatile oil set free by their sebaceous follicles.

The nervous system has a very decided action upon the cutaneous odor, which quite frequently is heightened or modified by mental excitement, depressing passions, and neurotic disease. Gambrini has recorded the case of a young man who, having been crossed in love, became violently jealous, after which his whole body exhaled a fetid, sickening, and very tenacious odor. Dr. Hammond, of New York (*Med. Rec.*, July 21, 1877), speaks of a hypochondriac whose skin diffused the fragrance of violets; of a hysterical female who smelt of pineapple during her paroxysms, and another who perspired on the left half only of her chest, whence she exhaled an odor like that of the iris; her sweat, when analyzed, was found to contain a butyric ether. In cases of localized perspiration, these curious oosphresiological anomalies are not at all uncommon. Schmitt knew a man who labored under a hyperidrosis that affected his hands only, and smelt like sulphur. Orteschi met with a young girl who exhaled, without any possibility of fraud, a strong odor of vanilla from the commissures of her fingers. Barbier mentions the case of a captain of infantry, the upper half of whose body was subject to an offensive perspiration which resisted all treatment, and finally obliged him to resign his commission. All these are examples of disordered innervation. Thus, as Hammond remarks, we perceive that the phrase "odor of sanctity" is not a mere figure of speech; it embodies the idea of a *holy neurosis*, which imparts to the skin a perfume more or less agreeable—at least during the actual access of the devotional ecstatic paroxysm.

The foregoing facts are curious merely. We now come to others which are of practical importance. In lethargy (hardly ever witnessed except in hysteric subjects), the very perspiration has a cadaverous odor, thus adding another touch to the perfect picture of death already presented by this condition. This odor, there can be no doubt, has aided in the production of some lamentable mistakes.

The smell given forth from the skin in mental disorders is thus described by Fèvre, in his work on the alterations in the cutaneous system arising from insanity (Paris, 1876): "The odor of the sweat in lunatics is of a very peculiar nature. Fetid and penetrating, it resembles the emanations from hands kept constantly closed, and is allied to those of the yellow deer and of mice. It is met with more especially in subjects of general paralysis and confirmed dementia. It impregnates the garments, bedclothes, and furniture of the patient, and even pervades his apartment, and is exceedingly tenacious, *despite the utmost attention to cleanliness*. This odor is so characteristic that Burrows declares *he would not hesitate, even in the absence of other evidence, to pronounce any person insane in whom he might perceive it*." Another English alienist, Dr. Knight, goes still further, claiming that the absence of this symptom enables him to discover when insanity is feigned.

The affection to which Hebra has given the name of *bromidrosis* consists in an offensive odor of the skin resulting from an abnormal condition of the *materia perspiratoria*, without any increase in the quantity exhaled. It may be confined to particular portions of the body. *Bromidrosis pedum*, for example, is quite a common disorder. Even kings have not always been exempt from this odious infirmity—witness some of the stories told about "Le Roi Soleil," Henry of Navarre, whose neighborhood was almost insufferable to his courtiers, and whose very mistress reproached him with smelling "like a carrion."

The inguino-vulvar and inguino-scrotal perspirations possess an aromatic odor closely akin to that of the genital region in either sex.

The axillary sweat owes its peculiar redolence to the alkaline caproates; also, to certain volatile and odoriferous free acids; for, as Robin observes, none of these bodily odors is caused by any single element, but always arises from a combination.

Hyperidrosis of the axillæ is not uncommon. It is especially apt to occur when the body is unclothed, and, in women, during the catamenia, at which period it diffuses an aromatic odor of acids or of chloroform.

Localized sweats, almost always of tropho-neurotic origin, have usually a strongsmell. This is probably due to maceration of the epidermis in the effused fluid—epithelial desquamation being also of frequent occurrence in all such nervous conditions. Weir Mitchell has observed that in lesions of the nerves the corresponding cutaneous region exhales an odor like that of stagnant water. This, we believe, is owing to a disturbance of the epithelial nutrition, rather than to any actual alteration in the sweat.

The ingesta, whether nutritive or medicinal, readily eliminate their odorous principles through the skin, and thus exert an influence upon the cutaneous odor. Garlic, alcohol, coffee, truffles, valerian, musk, turpentine, tar, sulphur and its alkalies, the fetid gum-resins, ethers, angelica, benzoic acid, iodine, and the iodides, phosphorus, etc., transmit to the integument their respective odors, more or less modified, according to the functional activity and also to particular idiosyncrasies. Copaiba diffuses its tell-tale fragrance in the same way. Sulphate of potassa is decomposed within the organism, and imparts to the sweat a hydro-sulphurous odor. Phosphate of zinc causes garlicky-smelling perspiration, etc.

In acute alcoholism the perspiration often has the odor of aldehyde, a peculiarity of value in diagnosis, as serving to distinguish the lethargic form of intoxication from apoplexy. Finally, I have noticed in the case of a lady who was

taking Fowler's solution of arsenic, the occurrence of very offensive axillary sweats, which ceased when the medicine, at her earnest request, was discontinued.

Sufferers from incontinence of urine smell of this fluid, or else like mice. Similarly, constipation gives rise to a fecal odor of the skin, which, when perceived by the subjects themselves, frequently aids in producing hypochondria, a condition to which this class of patients is always liable.

The "hospital odor" is essentially variable in character, being chiefly caused by an aggregation of cutaneous smells. Hence it is that the wards devoted to women and children are perfumed with butyric acid, while those of the men proclaim the presence of alkalies and ammonia.

In gout, the cutaneous secretions exhale a peculiar odor, likened by Sydenham to that of whey. Icteric patients smell of musk; syphilitics of honey; scrofula is marked by the odor of sour beer; intermittent fever by that of fresh bread. In diabetes, when there is perspiration, it smells like hay, or rather, according to one authority, like acetone; Bouchardt thinks that the odor in this disease is intermediate between that of aldehyde and of acetone, being due to a mixture, in different proportions, of these two bodies.

In cholera, Drasch and Porker have noticed an ammoniacal odor which they attribute to an elimination of urates in the sebaceous secretion.

In women recently confined and during the milk fever, the perspiration, especially at night, has a sour smell. Under the influence of pestilential maladies, the skin, according to Biembrock, exhales a peculiarly agreeable odor. Strange to say, this old-time observation has been confirmed by Döppner, who says that all the plague-patients at Vetlianka diffused an odor resembling that of honey.

In febrile conditions generally, the outer integument develops a sort of *moist* odor which is quite indescribable. Contagious fevers, as also the virulent disorders (rabies, glanders, and malignant pustule), are accompanied by a putrid smell.

In dysentery, the sweat reveals an unmistakable odor of the dejecta, as is strikingly evident on entering a hospital ward devoted to this complaint.

In typhoid fever, the cutaneous odor is remarkable. Béhier calls it an *odor of blood*, and Fred. Berard says that it will attract the flies even before life has left the body. However slightly manifested, it is always the immediate forerunner of death. Dr. Althaus reports that Skoda has never been misled by this indication, and Crompton, of Birmingham, also mentions it as an important clinical symptom. This effluvium of the moribund is quite unlike the death-smell itself, which again is also *sui generis*, and not at all allied to the odor of putridity.

Classical authorities are quite at sea about this typhoid emanation. It is truly what Béhier describes it—an odor of blood. The *mouse-like* smell belongs more properly to typhus. It is consequently absurd to maintain, as Hjaltelin does, that these two fevers are marked by the same odors, and to infer from thence their mutual analogy.

A putrid odor, of variable character, is observed in pyo-septicæmia, scurvy, bilious remittent fever, and the watery cachexia, or Egyptian chlorosis, of Griesinger. Recently established theories concerning the alterations caused by these disorders in the cutaneous secretions, afford an explanation of this symptom. As for the ammoniacal odor which has been remarked in the course of cerebral affections, we think, with Lallemand, that it is often caused by an incessant urinary overflow.

In acute articular rheumatism, the sweat becomes more acid in proportion to its abundance, especially about the swollen joints. Its odor becomes markedly sour and penetrating. Some authors attribute these qualities to an excess of lactic acid, but are they ignorant that this latter is itself without smell? The odor in question is clearly due to the presence of acetic and formic fatty acids, whether these exist originally in the rheumatic sweats, or result from a transformation of the cutaneous secretions in their entirety, and not at all (as Ernest Besnier contends) to the abundance of the sweats, and their retention and decomposition, favored by a high temperature, by the immobility of the patient, and by the saturation of his long-worn garments. In refutation of this latter idea, it is sufficient to point to the profuse perspirations in phthisis, which never smell like those of rheumatism; neither can the rheumatic odor be prevented by frequent changes of linen or by the utmost attention to cleanliness.

In miliary sweats, the odor, at once acrid and nauseating, has been likened by epidermological writers to that of vinegar, rancid oil, mouldiness, and rotten straw; this last comparison being, in our opinion, the most accurate. This variety of perspiration ferments very easily, and hence has been described as smelling like "spoiled vinegar."

We now come to the cutaneous odors connected with the eruptive fevers. Hebra quotes Heim, of Berlin, as maintaining that each of these complaints has its peculiar odor, recognizable by the experienced physician. In measles, we have the smell of feathers freshly plucked; in scarlatina, that of bread hot from the oven; in small-pox, that of the yellow deer, or of a menagerie. These odors, in Hebra's opinion, "are not pronounced enough to be regarded as characteristic," a criticism which we do not consider altogether just. Some of Heim's picturesque comparisons may perhaps be drawn from his imagination, but there is certainly a marked difference between the cutaneous odor in the suppurative stage of variola and that in a case of measles.

Skin diseases of whatever kind, when seated on the genital organs or the anus, between the toes or in the axillæ, exhale the odors peculiar to their respective localities, but with a still higher degree of fetidity. Scrofulous sores, lymphatic dermatoses, eczema, impetigo, *croûtes de gourmes*, etc., have a feebly acid or mouldy smell. Sebaceous acne exhales a nauseous, rancid odor, which is *sui generis*. *Eczema pilaris* has a repulsive fetidity, probably due to retention of extravasated products. *Rupia* is not only of hideous aspect, owing to its scabs and purulent exudations, but is prominently characterized by its offensive odor. *Pemphigus* discharges a serum which normally has an insipid smell. When this changes to gangrenous, it announces the appearance of a malignant septicæmic form of the accompanying fever.

The odors of impetigo, of *rupia*, etc., are doubtless derived from the decomposition of the muco-purulent secretions in those diseases, and from the maceration of the exfoliated scabs in the altered fluids of the pustulous bullæ.

The hair possesses a normal odor which is peculiar, but scarcely definable. It varies in different races; the hair of the Chinese, as is well known, has a natural smell of musk, which cannot be washed off even with the aid of strong chemicals.

Hairs lose their odor after falling off. Barbers can tell at once, by simply smelling at a lock, whether it was cut from the living head or made up from combings.

In hysteria, and especially in hysterio-epilepsy, the hair takes on, during

the paroxysm, a specific odor which is always the same, and resembles that of ozone.

In tinea favosa, the odor of the scalp affords a valuable diagnostic indication well known to all dermatologists. Offensive and nauseating, it has been compared to the smell from a nest of mice, to that of cat's urine, and to marshy effluvia. It grows worse as long as the disease continues, but may be lessened, though never entirely got rid of by attention to cleanliness. It is eminently characteristic of the complaint, and after having been once recognized, can never be mistaken.

This odor is entirely distinct from that of the pseudo-tineæ, especially the *tinea granulosa* of Alibert, which is a simple impetigo of the scalp, frequently offensive, but smelling like sour milk, not at all like mice.—E. MONIN, *Sur les Odeurs du Corps Humain*. Prize essay, Paris, 1885. (*Ann. d. l. Soc. de Méd. d'Anvers.*)

THE BACILLI OF SYPHILIS.

THE inquiries to which this article relates having been conducted without reference to the labors of my predecessors in the same department, I deem it unnecessary, on the present occasion, to enter into historical details, which, moreover, would merely be a repetition of what I have already published.

My examinations of syphilitic products have resulted in the discovery of a well-marked micro-organism very closely allied in its morphological relations and mode of staining to the bacilli of lepra and of tubercle, and also occurring, like the latter, in exuberant granulations. It measures, usually, from $\frac{3}{4}$ to $\frac{4}{5}$ mm. in length, by $\frac{1}{4}$ to $\frac{1}{10}$ mm. in diameter, and exhibits an irregularly undulating surface beset with slight indentations. It is also seen to form projecting spines, which appear as clear, oval-shaped, shining spots on the deep-colored bacilli, and are contained, to the number of from two to four, at equal intervals in each of them.

These objects were not found moving freely, but inclosed in cells that were sometimes twice the size of a white blood-corpuscle, roundish, oval, or irregularly polygonal in shape, and frequently containing nuclei in the form of clear spots on their centres or sides. The cells were more abundant on the borders of the infiltration, as also in the apparently healthy tissue immediately adjoining. They were likewise observed in connection with papulæ in the rete Malpighii, and imbedded in the spinous cells of the latter; also close to a sclerosis within the lumen of a large lymphatic. Being thus endowed, apparently, with the power of active locomotion, it is quite likely that they are migratory cells.

The technical processes by which these microbes were brought into view proved entirely ineffectual in the case of other fungoid parasites. They failed when applied to the products of splenic fever, typhus, glanders, endocarditis ulcerosa, croupous pneumonia, various wound-secretions, acne and itch pustules; also, as was to be expected, in the examination of normal tissues.

So far, sixteen cases of syphilis have been investigated in this way, *i. e.*, prepared sections from two scleroses, one lymphatic gland, three papulous efflorescences, and four products of the gummy stage; also, the secretions from three scleroses and as many moist papulæ. Positive results were obtained in each of these instances—although the number of bacilli detected was mostly inconsiderable, depending, apparently, upon the age of the infiltration and the period of time which had elapsed since the disease was contracted.

In specimens from two *soft chancres*, no microbes whatever were discoverable.

Equal diagnostic importance, I am inclined to think, attaches to the demonstration of the syphilitic bacilli in secretions, as to the presence of the tubercle-bacilli in expectorated matters.

In discharges from secondary lesions, the microbes were remarkably abundant, but their number diminished considerably after a short course of local treatment.

Since, therefore, undoubted syphilitic products of different kinds have always revealed the presence of a single variety of bacilli, distinctly characterized and hence to be regarded as specific; and since, in other contagious diseases, the uniform occurrence of peculiar micro-organisms is justly regarded as indicating their mode of origin, I consider it highly probable that the parasites I have discovered are *carriers of the syphilitic virus*.

Some of the facts already mentioned are strongly confirmatory of the theory that the syphilitic poison, after its primary deposition, is taken up first of all by the lymphatics, from which it subsequently passes into the general circulation.

The presence of migratory cells containing bacilli in the rete Malpighii agrees with the clinically observed circumstance that syphilitic infiltrations have only to part with their horny epithelial covering in order to become infectious.

Moreover, the detection of precisely similar organisms both in primary and secondary products and in typical gummatus formations, goes to show that these latter are to be regarded as genuine specific affections, and not as the results of a syphilitico-mercurial cachexia.

I cannot conclude without the expression of a hope that future researches, especially in the direction of pure cultivation and inoculation, may succeed in establishing an etiological connection between syphilis and the above-described bacilli, and thereby furnish us with an effective weapon against one of the most lamentable and widespread evils that afflict humanity.—SIGM. LUSTGARTEN, *Wien. Med. Wochenschr.*, No. 17, Apr. 25, 1885.

SYPHILITIC GUMMATA OF THE LARYNX.

SYPHILITIC gummata of the larynx are not so rare as generally supposed; they manifest themselves singly or in a multiple infiltrated form.

The epiglottis, the aryteno-epiglottic fold, the arytenoid cartilages, and the inferior vocal cords constitute their seat of predilection. Tobacco, alcoholic drinks, speaking, and singing are the principal causes which determine the localization of gummata upon the phonating organs. These lesions occur with equal frequency in both sexes.

Gummata are either superficial (gummous laryngitis, properly so-called) or deep (chondritis, peri-chondritis). We divide gumma into four stages: of formation, of softening, of ulceration, and finally of reparation.

Functional symptoms, and especially signs furnished by the laryngoscope, characterize the disease during these four periods.

The first stage is characterized by hoarseness, by slight pains, and by a redness and small indurations which are revealed by the laryngoscope.

The second stage is characterized by the same signs, and additionally by an engorgement of the cervico-maxillary glands and the development of gummata exhibited by the laryngoscope.

The third stage is characterized by a puffiness of the region of the neck, by

pain, increased on pressure and by deglutition, by hoarseness, raucity of the voice, and aphonia.

The laryngoscope shows an ulceration of the larynx of variable extent: its edges are perpendicular, with a peripheric areola and œdema of the aryteno-epiglottidean region; the ulcerated base is yellowish and covered with a thick, grayish matter.

Finally, the fourth stage is characterized by cicatrices and all the functional signs which accompany them. The diagnosis is quite difficult during the ulcerative stage of the gumma, because the ulceration may be confounded with all other ulcerations of the larynx. Still the antecedents of the patient, the ganglionic engorgement, the localization of the lesion and of the neighboring œdema, the laryngoscopic examination and, if necessary, specific treatment, will elucidate the diagnosis.

Syphilitic gummata are less serious during the first two stages, and by appropriate treatment their resorption may be effected without any unfortunate consequence. Ulcerating gummata are, on the contrary, very grave, not only on account of the immediate functional troubles which they provoke (œdema), but also from the stricture which they may leave as a result.

The treatment differs in no respect from the ordinary treatment of gummata in general. The results obtained by the administration of the syrup of Gibert will be much more satisfactory when this medicament is promptly given. The reparative process may be hastened by cauterizations. The œdema may be combated by cauterizations with chromic acid in solution (25 to 50 per cent) and by scarifications. If these means fail, it may be necessary to have recourse to tracheotomy, which, done promptly, gives good results.

The strictures may be combated by dilatation or by incision (Isambert) and, if necessary, tracheotomy.—DR. GEORGES C. LATOUPHIS, *Th. de Paris*, 1884.

CONTRIBUTION TO THE STUDY OF THE PIGMENTARY SYPHILIDE.

1st. The pigmentary syphilide is a cutaneous dyschromia in which two adjacent surfaces give us, one the perception of hyperchromia, the other the illusion of achromia. The hyperchromia presents itself in the form of islets, circles, or poly-circles contiguous to each other and more or less numerous. Isolated or confluent, their dimensions vary from the size of a lentil to that of a twenty-five-cent piece; the hyperchromia occupies the inter-insular spaces. The form is subordinate to the number and dimensions of the hyperchromic spots. The complexity of the phenomenon is admirably expressed by the term "dappled syphilide." But this term is not applicable to the accident either at its beginning or period of decline.

In its full development, the hyperchromic islets are geometrically circular; this geometric aspect is not present in either the initial or retrogressive stage. Its diagnostic value in the pigmentary syphilide is, by this fact, considerably lessened. At this epoch, also, the contrasts of color are not so marked, and the signification of the dyschromia is quite equivocal.

2d. In two-thirds of the cases, the pigmentary syphilide is quite visible, even from a distance; in the other third, it is necessary to search for it.

3d. It often appears shortly after the roseola, at the beginning of the secondary stage.

4th. Its duration is long, it may persist for years, and in certain cases it may continue indefinitely.

5th. It is extremely frequent in young women; it becomes quite rare after the twenty-fifth year; it is much more common in women than in men.

6th. Its seat of predilection is the neck, especially its lateral faces. It is sometimes found on the back of the neck, the shoulder, the region of the pectoralis major, and above the crural arch, rarely upon the extremities, very rarely on the face.

7th. It is not the posthumous expression of an anterior syphilitic eruption. It is a direct manifestation of the syphilitic diathesis.

8th. It does not appear probable that it is due to any alteration whatever of the blood. We are inclined to believe that the nervous system plays a preponderating rôle in its pathogenesis.

9th. Microscopic examination has demonstrated that there are pigmentary granules at the level of the hyperchromic islets. The microscope fails to enlighten us upon the double question: 1st, if there is a pigmentary rarefaction at the surface of these islets; 2d, if there is a pigmentary proliferation at the surface of inter-insular spaces. For, upon the neck, there is not a normal coloration; there are only variable pigmentations. Nevertheless, we think that, at the surface of the islets, there exists a rarefaction, or at least a defect of pigmentary renovation, and at the surface of the inter-insular spaces a compensatory pigmentation is produced.

10th. The dappled syphilide cannot be mistaken for vitiligo or discolored cicatrices. In the great majority of cases, the error may be so easily avoided that it may be considered as a pathognomonic sign of syphilis.

11th. It suffices to have seen a pigmentary syphilide only once in order to recognize it.

12th. The prognosis of the pigmentary syphilide presents no other gravity than that of the disease of which it is an expression.

13th. We are ignorant of any successful treatment of the pigmentary syphilide.—DR. MAIREAU, *Thèse de Paris*, 1884.

ON CERTAIN ALTERATIONS IN THE LYMPHATIC VESSELS IN THE COURSE OF SYPHILIS.

1. The lymphatic system undergoes an almost constant alteration in the course of syphilis. But while the ganglia are quite often modified, the lymph-vessels, on the contrary, are very rarely so.

2. The lymphopathies exist under many conditions, and may be divided into six clinical forms:

a. In the first place, there is a simple inflammatory lymphangitis consecutive to a specific ulceration, however excited.

b. A lymphopathy may complicate the infecting chancre, and then it bears the same relation to the lymphatic vessels as the adenopathy consecutive to the syphilitic chancre bears to the lymphatic ganglia.

c. There is observed a secondary disseminated lymphopathy, which evolves under the sole influence of the diathesis, without being under the dependence of a local manifestation.

d. In the tertiary stage, certain lymphatics, principally those of the dorsum of the penis, may become sclerosed, and give rise to a special lymphopathy.

e. A cutaneous manifestation of late hereditary syphilis may be complicated with lymphangitis having a special aspect.

f. Finally, in acquired, as in hereditary syphilis, there exist alterations of the

visceral lymphatics. These alterations, carefully studied from an anatomico-pathological point of view, occasion no characteristic clinical symptom which enables one to diagnose them.

3. Clinically, the different lymphopathies are particularly characterized by the existence of hard, mobile, indolent, aphlegmatic cords, situated exactly upon the anatomical course of the lymphatic vessels. For this the first and the sixth forms described are an exception. The first is an inflammatory lesion, and the sixth a visceral lymphopathy.

4. The treatment should be specific and constitutional. Mercurial frictions are injurious in these cases, because they may irritate the skin or inflame or alter the lymphatic vessels which are predisposed to phlegmasies by the fact of the syphilitic diathesis. In grave cases, subcutaneous injections may be employed which, despite their inconveniences, constitute a most energetic therapeutical measure.—DR. PAUL SALLÉ, *Thèse de Paris*, 1884.

PEMPHIGUS ACUTUS CONTAGIOSUS ADULTORUM.

UNDER this name, Dr. Erik Pontoppidan, in *Hospitals-Tidende*, April 1, 1885, describes a disease of which he has seen twenty cases in the course of a year. Kaposi, Lang, Weyl, and Geber, have published descriptions of similar cases, which proved to be *tinea trichophytina*, with tendency to exudation of serum under the upper layers of the epidermis, that are lifted up as large bullæ. But Pontoppidan has never been able to find vegetable parasites in these eruptions. On the other hand, the clinical appearance corresponds entirely with what was first described by Tilbury Fox as contagious impetigo. The only drawback is, that it is by no means an impetigo. The process does not extend beyond the deeper layers of the epidermis. The exudation is purely serous, in other words, we have to deal with a bullous formation, a pemphigus. Perhaps the disease is related to the acute contagious pemphigus of infants, in which Riehl recently has found vegetable parasites.

The observed cases presented a rather uniform type. A child or young grown-up person of the lower classes, who neglect personal cleanliness, presents himself with an affection of the face that, at the first glance, appears as a quite considerable skin disease, an old neglected eczema or burn covered with scabs. On a more careful examination, the face, to a greater or smaller extent, is found to be the seat of round, coin-like scabs of different age. Some of them are quite dry, dark-colored by dirt. They are not very adherent, and under them the skin is red, smooth, but otherwise normal. Others, of a younger date, are more fresh, moist, and adherent, and under them is yet found a little serum and a round, red, swollen, but not excoriated surface of skin. Often the spot is surrounded by a kind of collar formed by the remnants of the original blister. Finally, all transitions may be found to the fresh pemphigus vesicles, which may be like the blisters produced by cantharides, but less tense, more flat and fragile, so that they easily burst.

The patient relates that the affection has begun suddenly, a few days since, with the formation of blisters, which soon were transformed to scabs. The general health has not suffered. There has not been much itching. The patient comes mostly because the disease "looks so bad."

If one is sure of his diagnosis, he may confidently give a good prognosis. By any kind of protecting treatment, for instance, salicylic acid paste or zinc oint-

ment, the process will be cured in the course of a week or two. The scabs fall off, and leave red spots, which disappear without any trace.

The observed cases showed a distinct epidemic and contagious origin. They came in small groups about the same time, and in several cases, members of the same family or friends had acquired the disease from one another.

In rare cases, the disease affects other exposed parts of the skin than the face.

SYPHILIS AND TABES DORSALIS

THE figures of which Eulenberg avails himself in discussing the question of the etiological connection between syphilis and tabes dorsalis, refer to 125 cases, retained under his observation during a period of four and a half years. Of this total, 106 were men and 19 women; among the former, a large contingent was furnished by the railway service; only 2 of the women were unmarried. Twenty-eight of the 106 men had been affected by typical sclerosis and secondary symptoms; 11 had only had soft chancres, without constitutional sequelæ; the remaining 67 showed no evidence of ever having suffered from syphilis in any form. That is, infection (reckoning the *ulcus molle* as a variety of syphilis) had occurred in 36.8 per cent of the male patients. Among the women, syphilis could only be ascertained to have existed in a single case; in a few instances it was directly excluded. When the cases in which tabes had been preceded by syphilis were collectively regarded, no one symptom was found belonging to them all which was not also to be met with among the non-syphilitics.

Attention was likewise paid to the other causes of locomotor ataxy, and the influence of heredity was traced in 15 cases; that of exposure to weather in 62, and of such exposure combined with over-fatigue, in 42; of bodily exertion, in 34; of severe emotional disturbance, in 16; of the imagination, in 6; of acute diseases, in 5 cases of importance.

Such being the result of this numerical test, its author can hardly be thought to err in conceding to syphilis in this relation only the rôle of a debilitating agent, or of one predisposing to tabes, a rôle which is also performed by the other etiological factors above cited. He lays considerable stress upon the fact that tabes is not of frequent occurrence among prostitutes, and that a previous syphilitic infection appears to be without significance in its bearings upon the prognosis and therapeutics of the disease.—EULENBERG, *Virchow's Arch.*, Vol. 99 (*Wien. med. Wochensh.*).

SYPHILITIC ARTERITIS, ESPECIALLY THE ACUTE FORM.

SYPHILITIC arteritis may affect two different forms, one acute, the other chronic; the latter sometimes terminates in an aneurism.

Syphilitic arteritis may be found in any of the arteries of the body, but it is most often localized in the arteries of the head, the other vessels remaining healthy. It is a circumscribed, often symmetrical arteritis.

It presents two periods in its evolution: 1st, a period of induration, with the preservation of the lumen of the vessel; 2d, a period of obliteration of the artery with all its consequences.

Acute syphilitic arteritis has peculiar characteristics exhibited in its course and the special symptomatology which it produces. It should be studied along with chronic syphilitic arteritis.—DR. BAROUX, *Thèse de Paris*, Nov. 10, 1884.

TREATMENT OF VARICOSE ULCERS BY FREE INCISIONS.

1st. It is in the treatment of very extensive varicose ulcers that the procedure of M. Gay, modified by Dolbeau, has given the best results. It is especially in these cases that this method should be recommended.

2d. This procedure leads to rapid cicatrization. In five cases of varicose ulcers taken at random from the service of B. Onger and treated by this method, the average duration of the treatment was forty-one days.

3d. The cure appears to have been complete. We have observed, whenever it was possible to do so, these patients after their exit from the hospital, and a relapse did not occur.

4th. This method of treatment has given equally good results in the treatment of other varieties of chronic ulcers, and principally in ulcers consecutive to burns of the external integument.—DR. CHEVALIER, *Th. de Paris*, 1884.

HYPERTROPHIC SYPHILITIC CHANCRE.

HYPERTROPHIC syphilitic chancre has a prolonged evolution varying from three to seven months and which may on this account be sometimes confounded with cancrroid.

It is almost always extra-genital and is situated by preference upon the face.

Its diagnosis, which at first appears difficult, is singularly simplified by the appearance of secondary accidents and the coincidence of ganglionic engorgement.

Its prognosis is, in general, quite benign as a local lesion and this form of chancre does not indicate a greater gravity in the resulting syphilis.—DR. L. ZWETITCH, *Thèse de Paris*, July, 1884.

CERTAIN CONSIDERATIONS UPON GONORRHEAL ARTHRITIS.

GONORRHEA is a parasitic and virulent disease. It determines articular manifestations analogous to those which complicate all virulent diseases.

These manifestations present none of the characteristics of true rheumatism; and should not be confounded with this disease. They should be classed as arthrites.

They result from a special intoxication, due to the presence of a microbe in the organism.

The causes capable of modifying the intimate structure of the articulations play an essential rôle in their production.—DR. E. CHOTIER, *Thèse de Paris*, 1884.

Reviews.

THE OLEATES: AN INVESTIGATION INTO THEIR NATURE AND ACTION. By JOHN V. SHOEMAKER, A.M., M.D., Lecturer on Dermatology at the Jefferson Medical College, Philadelphia, etc., etc. Philadelphia: F. A. Davis, 1885.

As is well known, Dr. Shoemaker was chiefly instrumental in introducing this class of preparations to the notice of the profession, and no one is better qualified by practical experience to speak authoritatively concerning their therapeutical value.

The combination of oleic acid with medicinal substances has now been extended to embrace quite a large number of drugs in dermatological use. Not

only do they possess decided advantages in the treatment of many forms of skin affection; but on account of the remarkable penetrating power of oleic acid, they constitute, it is claimed, a superior mode of introducing the drugs into the economy, and thus securing their constitutional effects.

The little volume before us contains a résumé of all that the author has written concerning the oleates and their uses, together with much new matter, embodying the results of his later experience. To those of our readers who wish to learn all about the origin and history, the process of manufacture, the physiological action, and the therapeutic effects of a class of preparations which are destined to grow in favor as their merits become more generally known, we commend this little book.

Received.

Manual of the American Dermatological Association. New York, 1885.

Album Clinico de Dermatologia. Laminas Nos. 35 and 36. Publicados por la Revista de Medicina y Cirurgia Practicos. Madrid, 1885.

Monograph on Primary Sclerosis of the Tonsils, based on Three Cases Observed by the Author and Sixty-five cases by Others. By CHARLES SCHADECK, Kiev.

Cas Rare d'une Dystrophie de la Peau par ALEXIS POSPELOW. Extrait de *Annales de Dermatologie et de Syphiligraphie*. Paris, 1885.

Hay Fever and its Successful Treatment by Superficial Organic Alteration of the Nasal Mucous Membrane. By CHARLES E. SAJOUS, M.D. Philadelphia: F. A. Davis, Pub., 1885.

The Diagnosis, Treatment of Chronic Nasal Catarrh. By G. M. LEFFERTS, A.M., M.D. St. Louis: Lambert & Co., 1884.

Medical Thoughts on Shakespeare. By B. RUSH FIELD, M.D. Second edition. Easton, Pa.: Andrews & Clifton, Pub., 1885.

Acne Indurata: its Treatment. By HENRY W. STELWAGON, M.D. Reprint.

Impetigo Contagiosa: its Individuality and Nature. Same author. Reprint.

An Erythematous Eruption from Chlorate of Potassium. Same author. Reprint.

A Case of Feigned Eruption. Same author. Reprint.

Vlemminck's Solution in Acne Rosacea. Same author. Reprint.

Case of Phthiriasis Palpebrarum. Same author. Reprint.

The Oleates in Cutaneous Diseases. Same author. Reprint.

Superfluous Hair. The Russian Dog-faced Boy and Facial Hirsuties in Women. By GEORGE THOMAS JACKSON, M.D. Reprint.

Le Peronospora Ferrani et la Vaccination Cholérique. Par le DR. DUBORNEAU. Toulouse, 1885.

Bacterial Pathology. By WATSON CHEYNE. Reprint.

Some Notes on Small-pox. By JOSEPH GHRNDON, M.D. Reprint.

ETIOLOGY OF LICHEN ÆSTIVUS.—A Texas exchange says there are hot springs in Mexico that cure people of all eruptive diseases. That all depends on what kind of a hot spring the editor is writing about. A hot spring down here in Texas makes pimples, boils, and prickly heat come out all over some of our most respectable citizens. A hot summer is even worse than a hot spring.

Editorial.

CHRY SAR O B I N .

AT several recent meetings of the NEW YORK DERMATOLOGICAL SOCIETY, there have been informal discussions concerning chrysarobin (chrysophanic acid), and more especially in relation to its apparent deterioration in strength and activity. The experience of several of the members was given, and no one present contested the prevailing sentiment, that the chrysarobin now obtainable in this market was greatly inferior to the article furnished at the time of its first introduction. In other words, it requires two or three times as much chrysarobin to obtain a given effect as was formerly necessary. A few years ago, an application containing, say, five per cent of chrysarobin would usually produce an active dermatitis, and a prompt therapeutic effect. At present, we cannot obtain the same results from a ten-per-cent application.

The important position occupied by chrysarobin in cutaneous therapeutics at the present day renders any tampering with its quality a matter of serious concern, and with a view of elucidating the question, we are making an effort to ascertain all the facts in the case. To this end we have corresponded with several wholesale and importing druggists, and with others both in this country and abroad. So far as we can learn, most of the chrysarobin sold here comes from Merck, of Darmstadt; and to him, therefore, we must first look for an explanation of the matter in question. We here publicly call his attention to it, and tender him the full use of our columns for any statement he may think fit to make.

In order to ascertain whether the dissatisfaction is purely local (New York) or is more widespread, we respectfully invite our colleagues in other cities, here and abroad, to communicate their experience. Until the entire facts are before us, we suspend judgment.

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Original Communications.

DESQUAMATIVE SCARLATINIFORM ERYTHEMA.

BY

DR. L. BROcq,

Paris, France.

DESQUAMATIVE scarlatiniform erythema is characterized by an initial stage of pronounced fever, similar to that of scarlatina; by an intense redness of the entire cutaneous surface, which subsequently peels off in flakes; and by the occurrence of complete recovery in from three to six weeks. Apparently, the disease is non-contagious. The dermatologists, Besnier and Féréol, by whom this group was first classified, prefixed to its title, as given above, the designation of "relapsing," because, after the subsidence of a primary attack, the eruption occasionally reappears—though in a somewhat milder form—three or four times in succession, or even oftener.

History.—The first clearly described cases of this disorder were those published by Benjamin Gooch,¹ and by John Latham.² No others are to be met with in medical literature down to 1829, when Thomas Newell³ reported a solitary example. Since then the eruptions we are speaking of appear to have been confounded either with pityriasis rubra, or with general exfoliative dermatitis. Thus, Tilbury Fox⁴ relates a very remarkable case of what he calls *an anomalous form of pityriasis rubra*;

¹ "Account of a Singular Separation of the Cuticle." Philos. Trans., 1769, p. 281.

² *Ibid.*, 1770, p. 451-453.

³ "Case of Exfoliation of the Epidermis" (London Medical Gaz., vol. iii., April 4, 1829, p. 976).

⁴ "Skin Diseases," p. 258.

and another well-marked instance is adduced by Percheron, in his thesis, where it is classified, along with those described by Goode and Latham, as a second form, or pseudo-exanthematous variety, of general exfoliative dermatitis. Henceforward, however, cases of this sort become more abundant. Two are cited in Derreasaix's thesis¹ in 1876. A highly typical one was communicated by Féréol to the Paris Hospital Society;² and in the discussion which ensued, it was maintained by Besnier, E. Vidal, and Féréol that the disorder in question was a hitherto unrecognized morbid entity differing entirely both from the "herpetide exfoliative" of Bazin (Besnier) and from general exfoliative dermatitis (Vidal); this newly discovered group they would designate as *relapsing desquamative scarlatiniform erythema*, and would place it in the class of pseudo-exanthemata. This distinction was not fully apprehended by succeeding French authors, who sought to identify with desquamative scarlatiniform erythema the cases described in England under the name of pityriasis rubra. Yet we may find in their treatises scattering but unequivocal references to the disease under consideration (Case I., in Bussy's thesis.³ Cases I. and II., in Collard's thesis.⁴ Case I., in Tremblay's thesis.⁵) Chevallier Preston⁶ not long ago described a case which was undoubtedly of this sort. I myself have observed several others—one at the Hôtel Dieu in Paris, reported by my friend and colleague Richardière,⁷ two at the St. Louis Hospital, in the service of Professor Fournier; finally, a very characteristic example in private practice. This inclines me to believe that the affection is not of very rare occurrence, and that it eludes recognition in the great majority of instances.

In Germany, too, it has been described by Vogler de Wetzikon,⁸ under the name of *recidivirendes exanthem*; by Buckardt-Merian⁹ under that of *recidivirendes scharlachähnliches exanthem*; by Daniel Bernoulli¹⁰ under that of *exanthema scarlatinoïdes recidivum*. But the question speedily became involved in complications, since Brandt,¹¹ of Fuessen; Friedrich Engelmann,¹² of Kreuznach; Adolph Kuehn,¹³ and Daniel

¹ Paris, 1874. "Sur l'Erythème Scarlatiniforme Rhumatismal."

² Union Méd., No. 29, 1876.

³ Paris, 1879, p. 18. "Etude sur l'Exanthème Scarlatiniforme."

⁴ Paris, 1877, p. 23 *et seq.* "Sur l'Erythème Scarlatinoïde Généralisé."

⁵ Paris, 1875. "De l'Erythème Desquamatif Scarlatiniforme."

⁶ "Remarable Case of Periodical Peeling of the Cuticle." (Lancet, Oct. 22, 1881.)

⁷ "Annales de Dermat. et de Syph.," June, 1883.

⁸ "Corresp. Blatt für Schweizer Aerzte," No. 13, p. 391, 1876.

⁹ Ibid.

¹⁰ Ibid., No. 5, p. 134, 1875.

¹¹ Berlin Klin. Wochens., p. 718, Dec. 1, 1879.

¹² Ibid., No. 43, p. 647, Oct. 27, 1879.

¹³ Ibid., No. 4, p. 50, Jan., 1880.

Bernouilli himself,¹ were not slow in bringing forward cases of desquamative scarlatiniform erythema in which relapses had been caused by the administration of drugs, and in raising the question whether all previously-described instances of this complaint ought not to be regarded as belonging to the great class of medicinal eruptions. Thus, for example, in a paper by Allan Jamieson,² Cases 5 and 6, to which he gives the title of acute exfoliative dermatitis, were probably nothing but drug-exanthems produced by large doses of chloral, of bromide of potassium, and of salicylate of soda. Obviously, then, it is necessary to take this element into account when investigating the subject. I shall make all due allowances on that score; yet it is my firm opinion that genuine cases of primary desquamative scarlatiniform erythema have undoubtedly originated outside the sphere of any medicinal influence. Such are the cases which have fallen under my own observation, and which warrant me in presenting the following delineation of their type.³

Description.—An attack of relapsing desquamative scarlatiniform erythema is generally ushered in by the following constitutional symptoms. The patient first complains of slight malaise,^a a sense of painful lassitude, he is then seized with a rigor, which may be either slight or severe, and resembles that which precedes pneumonia; sometimes there are only frequent shiverings—in one case these continued for three days. Next, a febrile movement sets in, but its precise manifestations are difficult to determine, since patients seldom enter the hospital until three or four days after the commencement of their illness. From what they report, it would appear that the fever reaches its highest point during the first two or three days of the complaint. If this be so, it must be quite severe

¹ "Corresp. Blatt für Schweizer Aerzte," No. 2, p. 37, Jan 15, 1880.

² Edin. Med. Jour., 1880, p. 879.

³ It is not at present my intention to enter upon any detailed account of the pathogenetic scarlatiniform exanthemata, which ought strictly to be classed among artificial disorders. I will merely remark that they are usually of very brief duration, and may result from the ingestion of either food or drugs. 1st, *Foods.* Among fish, the gold-headed doree, carangue, herrings; the crustacea in general, as crabs, lobsters, shrimps, etc.; the mollusca, especially mussels; certain vegetable products, as strawberries and water-cresses. 2d, *Drugs.* Ether and chloroform, by inhalation; chloral hydrate (Watson); balsam copaiba; opium [Seguin (Arch. of Medicine, New York, p. 10, 1879); iodine (Fisher); Mercury (Alley, 1810, Briquit (Arch. Gén. de Méd., 1838 and 1839), Baron (Gaz. Méd., 1850), Watson (Boston Med. and Surg. Jour., July 18, 1873)]; sulphate of quinine [P. A. Morrow (New York Med. Jour., March, 1880), Heinrich Kobner (Berlin Klin. Wochens., No. 22, p. 305, 1877, and No. 23, p. 325), Scheby Buch (Ibid., No. 37, p. 547, 107, 1877), Pflüger, of Berne (Ibid.), Ricklin (Gaz. Méd. de Paris, 1877), Garraway and Hemming (Thèse de Jeudi de Grissac, 1875)]; datura stramonium and belladonna (Jolly, Dubreuil, Bazin, Tardieu, Hulinel, Dreyfus); benzoate of soda [Hampelin (St. Petersburg Med. Wochens., No. 3, 1881)]; opium and ipecac, ipecac and rhubarb, Dover's powder, calomel, etc.

at the outset, since it is not uncommon for the axillary temperature to range between 38° and 39° C. on the fourth or fifth day. The skin is hot; the pulse frequent (100 to 110). Nausea and retching are very rarely met with; there may be some anorexia, but it is never a decided symptom. No diarrhœa—the bowels are generally constipated. A good deal of pain is sometimes experienced in the back and limbs, as well as very severe headache; occasionally there is anxiety and insomnia. Frequent epistaxis may take place, the perspiration may be excessive, but in most cases is entirely suppressed. In this stage, however, the only constantly-observed symptoms are the fever and the state of general malaise.

These precursory phenomena are of variable duration; sometimes they are very short-lasting, and the eruption comes out almost suddenly; sometimes they continue for several days (three days in one of my cases) before the slightest redness is perceptible on the general surface. Quite often the eruption first shows itself in the form of small, red, itching spots accompanied with some swelling of the integument. Patients say that, in the beginning, they have frequently noticed a number of small, red, dry pimples, which subsequently enlarged and became confluent. In other cases, their attention was first attracted by a large patch of a uniform color, and which rapidly increased; sometimes again the bodily surface presents a scarlet hue, or is covered with minute red papules, which change into a uniform investment of the same color. The itching in some cases is severe enough to compel scratching; in others it is hardly noticed, being thrown into the shade by a pricking, a smarting, or a sense of pungent heat, which is almost intolerable.

These distressing phenomena may precede the appearance of cutaneous redness; but they are not constant in their occurrence; they may be very moderately felt, or almost entirely absent; and however severe at their outset, they speedily subside, and may even cease altogether before the eruptive process is completed.

It is hardly possible to indicate the precise point at which the cutaneous manifestations take their rise, but it is certainly a very variable one. The eruption may begin on the upper portion of the body, and travel downward to the feet (Féréol's cases), or its advance may be in the opposite direction. In one case, its earliest appearance is on the superior and internal surface of the thighs; in another, it first invades the wrists, extending in succession to the arms, the forearms, the axillæ, the legs, and the body; in still other instances, it seems to have attacked several localities simultaneously.

Wherever it may begin, it tends to diffuse itself over the whole surface, most frequently reaching this consummation very speedily, even within the first twenty-four hours, although in some very rare instances from four to six days may be required. The head and the extremities—

hands and feet—are apparently the last parts to be invaded. In what we judged to be two cases of this disease, the head remained entirely untouched, which would seem to show that the eruption may sometimes not be universally diffused.

When completely developed, it is characterized by an intense and uniform redness, which, however, exhibits brighter or darker shades at different localities. The face is usually less discolored than any other part, though sometimes it is as red as the body. The anterior portion of the neck and chest is not so red as the nape of the neck, the back, and more especially the abdomen, in which situations the eruption assumes a somewhat darker tinge. The outside of the arms is often lighter colored than the rest of the upper extremities. The external surface of the thighs is likewise of a paler hue than the internal, and also than the legs. The palms of the hands and soles of the feet, owing to the thickness of their epidermis, show but little redness until desquamation has taken place.

Under finger-pressure, the cutaneous redness in most cases almost wholly disappears, and is replaced by a slight yellowish tint; not infrequently, however, this effect is only partially produced, the resulting color being a reddish-yellow. In one case, the eruption was observed to assume a hemorrhagic appearance, and in a patient of my own, it was accompanied by a considerable degree of general œdema, which extended even to the face. Most generally the integument shows a little puffiness at an early period, but this quickly disappears, so that only a slight thickening of the skin can be perceived on pinching it up between the fingers. The fact, moreover, that the change in question involves the whole cutaneous system, renders it in this instance still more difficult of detection. Yet, in one very well marked case, a certain degree of œdema could be made out as late as the fourth day of desquamation (eighth of eruption), in consequence of the patient's forehead pitting slightly under pressure.

When the redness has lasted a certain time, it is succeeded by *desquamation*. This sets in about three or four days after the eruption has overspread the entire surface, but the exact time varies in different cases. In some it seems to have been shorter than the above; in others, desquamation was delayed until ten days after the eruption had declared itself. The length of the interval must evidently depend upon the intensity of the morbid process, and upon the rapidity with which the general integument becomes involved, since, when several days are required for the full development of the eruption, those patches which were first formed will be the first to desquamate, and will have passed through this stage before the eruption has completed its extension; such cases, however, as we have already remarked, are very exceptional.

The desquamation commences with a small superficial fissuring of the epidermis; the cracks widen and extend, the epidermis between them rises and loosens, turns to a pearly white, and gradually becomes detached in flakes. It is difficult to say where this process commences; possibly it follows the same course as the preceding discoloration: at all events it may be affirmed that desquamation takes place wherever there has been redness. It is chiefly distinguished by its dryness and excessive abundance, the scales being swept in handfuls from the patient's bed every morning (in one case, three litres of them were accumulated in five days). On certain localities the scales are furfuraceous, but almost universally they appear as large, very thin and transparent flakes; sometimes, however, they are thick, yellowish and opaque, or thin, and of a dead white color, like unpolished glass. They occasionally measure as much as several centimetres in diameter, by one or two in height, are quite irregular in shape, and often shrivelled or frilled at their free borders. They may be adherent at one of their sides, all the rest of them floating loosely; or they may be fastened at the centre,¹ their unattached portions resembling a lady's lace collar. From a descriptive point of view, they are divisible into two classes: 1st, the *full-grown scales*, which are almost ready to fall off, and for the most part are large and but slightly adherent; these overlie, 2d, the *immature scales*, or those in the earlier stage of their growth, fine, furfuraceous, scarcely visible, and firmly adherent. Upon this second layer there is microscopically discernible a series of small, hard, white elevations, formed by an accumulation of epidermis in the glandular orifices. When the difficult task has been accomplished of scratching off all the scales, a smooth, glistening, and somewhat moist surface is disclosed. The eruption itself is always dry, never exuding in the least, even at the bends of the joints, except under the influence of irritating applications. In a single case, moisture was observed upon the genital organs.

It will readily be understood from this description that the general appearance of the affection may vary from time to time, according as the skin is covered with full-grown scales or with those that are immature.

On the *scalp*, the *eyebrows*, the *beard*, and the *mustache*, the scales are fine, furfuraceous, very abundant, and firmly adherent, sometimes forming a thick mass of a yellowish-white color. They are perforated vertically by the hairs, and do not overlap them, as in eczema. On the *forehead* and *eyebrows* they are fine, but already somewhat lamellated. They are frequently found in thick layers at the root of the nose, at the naso-labial furrow, and in the concha of the ear. On the *tip of the nose* they are very fine, somewhat thick, and quite broad; on the *cheeks* they are furfuraceous. The *face* presents a floury appearance, which would make it

¹ Vide description of the scales in general exfoliative dermatitis.

a good deal like that of the clown in a pantomime—provided that the clown's skin underneath were of a bright red color.

On the *neck*, the full-grown scales attain their largest size. All over the *body*, they are large, thin, uneven, rolled up at their free edges, or of a dull white color. On the *deltoid region*, they are thin and transparent, although still of a dull white color, slashed and curling at their free borders, and measure three centimetres in diameter by one in height. In one case, I found the *inner surface of the arms and forearms* covered with thick scales, almost yellow at some points, opaque, and forming a sort of shell like that of a turtle, loosely adherent and crossed diagonally by small superficial wrinkles. These scales, at first sight, irresistibly remind the observer of psoriasis. I cannot say whether such an arrangement is frequently met with.

The *back of the hands* not infrequently exhibits a very peculiar kind of desquamation—the scales, which measure several square centimetres, being transparent, but thick, hard, and, as it were, glued upon the skin, from which they are only slowly and gradually detached in the course of several days. This appearance is also especially well-marked on the *palms of the hands and on the fingers*; the skin of the latter, previous to desquamation, is tense, shining, hard to the touch, and apparently somewhat elastic. They appear as if covered with a thick layer of collodion or of court-plaster. Then the epidermis becomes yellowish and peels off in broad, hard, almost horny flakes, which sometimes form only a single layer on the palmar surface of the hands, exactly corresponding to the glove-like desquamation observed in scarlatina. Here the process takes place much more slowly than on the rest of the body. When this first layer hardens and falls off, it leaves a red or pinkish surface dusted over with a few fine furfuraceous lamellæ, but these are never followed by the large flaky formations which have just been described.

Over the *pubis* is found an accumulation of epidermic scales. The genitals and cleft of the anus are of a bright red color, and scantily covered with small thin scales. On the *thighs and legs* the scales are large, of a dull white color, and curly at their edges; they attain their greatest size in the neighborhood of the *knees and instep*, where they measure as much as 5 to 6 centimetres in diameter, and resemble leaves of gold beaters' skin. The soles of the feet, like the palms of the hands, desquamate quite slowly, and their epidermis comes off all at once in the form of sandals.

The *mucous membranes* are not always exempt from the above visitations. Thus, in seven out of eleven carefully observed cases, the affection began with an *erythematous angina*, not at all severe, it is true, but distinctly characterized by some degree of dysphagia, and by marked redness of the isthmus faucium. In several instances, the *conjunctive*, especially

of the eyelids, have been injected and painful; but the functional symptoms of blepharitis do not seem to be uniformly in correspondence with these phenomena, since, in one of my cases, the patient made no complaint of "sand in his eyes," although the conjunctivæ were bright red. In most cases, the *tongue* at the outset is rather white, then it seems to part with its epithelial investment, becoming smooth, glazed, raw-looking, and of a bright red color. Sometimes there is a sensation of dryness and pricking in the organ.

Among the epiphenomena of the eruption, *miliaria* have been noticed in one case at its commencement—a rare complication, apparently; in another, which fell under my own observation, there was an outbreak of *fever-sores* on the nose and lips. In the instance recorded by Homelle, the epidermis was raised in bullæ, like those caused by a fly-blisters, upon the legs and instep; the eruption was likewise somewhat moist over the lower portion of the thighs.

Almost all the patients complained that their skins felt dry. The insensible perspiration seemed entirely suppressed, in these cases. Quite frequently, a marked sensation of coldness was experienced after undressing.

Constitutional symptoms are almost wholly absent after desquamation has set in. During the first days, the fever is still quite high towards evening (38–38.5° C.; pulse 80 to 100); but soon disappears entirely. The patient's appetite returns, and his strength is fully restored, even before the termination of the eruptive stage. The itching and smarting sometimes persist to the very last, becoming, however, much less troublesome. In one case, there was such urgent thirst, that the patient drank about six litres of *tisane* daily, and his kidneys were acted upon accordingly. Neither sugar nor albumin, however, has been detected in the urine. Bronchial and cardiac complications are equally unknown. Almost all the subjects declared that, were it not for the redness and desquamation, they would have felt as well as usual.

Course—duration—termination. Desquamation generally goes on as above for about a week, during which the complaint remains stationary, then gradually becomes finer and more furfuraceous until it ceases, after a period varying from a week to a month, but averaging fifteen to eighteen days. The redness may disappear very rapidly, but in most cases becomes more intense as desquamation approaches; sometimes it continues throughout, but gradually loses its vividness and assumes an earthy appearance.

The last traces of the eruption are visible on the *nails*. A furrow, more or less deep according to the intensity of the desquamative process, is formed across the roots of those organs; and when, as is not infrequently the case, there are several successive attacks of erythema, each

one of them gives rise to a fresh furrow, so that a single nail may exhibit several. The nails of the thumb and index finger are those which are most conspicuously marked in this way. When desquamation has been very active, the groove will be especially deep—so deep as apparently to separate the nail into two distinct portions, an anterior and a posterior (the latter being that which is formed after the eruption). The anterior portion is gradually pushed forward by the newly-formed layers, which may even replace it from underneath. Hence it is that in some cases the old nails are said to have fallen off at the end of three or six months, after having been lifted out of position by the new ones. In one case, however, we observed that the nail of the little toe fell off on the twentieth day of the affection; perhaps the more important nails may in other instances have been detached as rapidly, but we have never met with any distinct statement to that effect. It does not appear that in this affection mortification of the entire matrix unguis and sub-ungual derma has ever taken place, as it does in cases of exfoliative dermatitis. We are supported in this opinion by the fact that falling of the hair is quite an exceptional phenomenon in desquamative scarlatiniform erythema, while it is the rule in general exfoliative dermatitis. These positions, however, are by no means taken unreservedly, since, in three cases of what appeared to be genuine relapsing desquamative scarlatiniform erythema, the hair is stated to have fallen off during the first attack, which was a very protracted one. This would seem to show that it is hardly possible to demonstrate any radical difference between an initial invasion of erythema and a slight attack of general exfoliative dermatitis.

Relapses.—One of the most striking characteristics of desquamative scarlatiniform erythema is its tendency to relapse, and that not once only but repeatedly. A first attack is usually a very serious affair, lasting from a month to six weeks, and sometimes resulting in the loss of the hair and nails; then, after an interval varying from a few months to several years, there may be a second one, not so severe. This is soon followed by a third, after which successive seizures occur with increasing rapidity, until they may even merge into one another, as in the cases recorded by Féréol and Richardière. At the same time they seem to become shorter and milder. If the hair and nails have been lost in consequence of the first attack, they are affected but slightly by the second, not at all by the third, etc. The duration of these relapses may be a fortnight, or even less (Tilbury Fox). They may occur once a year, as in Goode's and Latham's cases, or twice a year, as in my own and Newell's. Féréol's patient was having the disease for the eighth time, as also was Richardière's; Colard's for the seventh. Tilbury Fox's had had 100 returns of it at least.

I cannot say positively whether this complaint relapses as a uniform

rule; very possibly it does not. In this case ought the group under consideration to be divided into two sub-varieties—1st, *Relapsing desquamative scarlatiniform erythema*; 2d, *Non-relapsing ditto*—and should these sub-varieties be regarded as distinct affections? Further investigations are required for the settlement of these questions.

Histology.—The pathological anatomy of desquamative scarlatiniform erythema is as yet wholly undetermined. It is so closely related, however, to general exfoliative dermatitis, that the two complaints should present almost identical lesions (vide general exfoliative dermatitis).

Etiology.—Desquamative scarlatiniform erythema is a rare disease. All told, I have scarcely been able to collect fourteen indisputable cases. The doubtful instances are much more numerous. It affects persons of every age, but from 20 to 40 is the period of greatest liability to a first attack. It occurs most frequently in persons but little subject to perspiration—whose skin is habitually dry. Concerning the influence of occupations nothing of importance has been ascertained. Of the above-mentioned fourteen cases, eleven were men and three women, from which it would seem that the male sex is more predisposed to the complaint. Scrofula appears to take no part whatever in its development; but so much can hardly be said of the arthritic diathesis, since several patients were ascertained to have previously suffered from pains in the joints, hemorrhoids, and dyspepsia. As to the effect of the seasons in advancing or retarding the eruption, the evidence at hand does not enable us to speak with certainty.

Diagnosis.—To distinguish desquamative scarlatiniform erythema from *scarlatina* is at once easy and extremely difficult—easy when the eruption has already made repeated appearances; difficult when we have a first visitation of the malady to deal with. Frequently, in the latter event, we imagine that a case of eruptive fever is on our hands, until the redness is seen to continue after the eighth day of the exanthem, and desquamation has occurred several times and become exceedingly abundant, when we are compelled to a diagnosis of desquamative scarlatiniform erythema. The onset of the latter, also, is less abrupt than that of *scarlatina*; the febrile reaction is perhaps less severe; the angina not so marked, or possibly absent altogether. On the other hand, the redness of the skin is much more pronounced; miliaria are of rare occurrence; desquamation is far more abundant and frequently repeated, and exhibits much more of a lamellated character. The local symptoms, too, are very decided, while constitutional symptoms are trivial or wholly wanting. The complications (buboes, endocarditis, renal congestion, etc.) so frequent in *scarlatina*, are never observed in scarlatiniform erythema. Finally, the latter affection is non-contagious. Notwithstanding all these distinctions, desquamative scarlatiniform erythema was confounded

with scarlatina, even down to recent times, and this fact affords an explanation of certain anomalous features which have been ascribed to the more familiar affection (long duration, relapses, etc.).

The slight and transient *scarlatiniform erythema* described by Hardy is distinguished from desquamative scarlatiniform erythema by its brief duration—forty-eight hours in the average—by its benignity, and by its very scanty and furfuraceous desquamation.

I need not dwell upon the differential diagnosis, in each particular case, between desquamative scarlatiniform erythema and *erysipelas*, *lymphangitis*, *eczema rubrum*, *scarlatiniform psoriasis*, *exfoliative herpes*, and *pityriasis rubra pilaris*, from all of which it is readily distinguished by its universally diffused redness, the abundance and peculiar formation of its epidemic scales, the dryness of its eruption, and the regular stages through which its evolution is accomplished. Its relations with *general exfoliative dermatitis* and with *pityriasis rubra*, both serious and benign, will be discussed on a future occasion.

It has been already mentioned that the disease we are considering cannot be regarded as simply the result of drug-medication, as identical with the *pathogenetic desquamative scarlatiniform erythema*. The cyclical character of its development, and its protracted duration, suffice to set it widely apart from eruptions that are purely artificial, and that usually disappear immediately on the suppression of their causes.

Prognosis.—The prognosis in cases of desquamative scarlatiniform erythema is decidedly favorable. The cutaneous manifestations usually subside within a determinate period without occasioning any serious disturbance. The possibility of an indefinite number of relapses affords the only ground for apprehension.

Treatment.—When attending a first attack of desquamative scarlatiniform erythema, and not quite sure of our diagnosis, we should be guarded in our expressions of opinion, and should treat the case as one of scarlatina, keeping the patient in bed, protecting him against cold, and being careful that he does not overeat. When in no doubt as to the nature of the case, we may endeavor to allay the violence of the eruptive symptoms, and to moderate the desquamation, by inunctions with a glycerole either of simple starch, or containing one gramme of tartaric acid to twenty grammes of glycerole. Simple ointment is likewise an excellent application, provided it is quite fresh, and the same may be said of vaseline. Frictions with linseed-oil and lime-water may also be employed, after which the surface should be covered with layers of wadding. Sedative baths have also an excellent effect. As to internal medication, I believe it best to abstain from all powerfully acting remedies, especially arsenic. We should be content with prescribing some alkaline mineral water, as that of Vals or Vichy, a bitter *tisane*, the free use of

milk as a diuretic, saline purgatives, if the bowels are unduly confined, and in general a wholesome, progressive, and invigorating dietary, excluding all highly-seasoned and irritating articles.

RECENT ADVANCES IN DERMATOLOGICAL THERAPEUTICS.

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IT is undoubtedly the general verdict of every intelligent physician in general practice that the treatment of cutaneous diseases, as a whole, is not generally as satisfactory, either to himself or patient, as other departments of practice. The principal reason for this is the little attention given to the subject by the general practitioner.

While I may not be able to instruct you, yet I hope to gain a sufficient amount of your attention to awaken an interest and stimulate a desire for investigation in this department of the practice of medicine.

The methods of treatment which I have outlined are a review of some of the more recent advances in cutaneous therapeutics.

It is not to be understood, however, that the remedies mentioned in this paper are recommended as the best or only remedial agents to be used in each instance in the management of the various diseases under consideration to the exclusion of other and well-recognized plans of treatment, but as supplementary thereto.

I wish to direct your attention, first, to a class of preparations but a very few years ago introduced into cutaneous therapeutics, and known by the general designation of the oleates.

The advantages which it is claimed the oleates possess over ordinary ointments are the following:

- 1st. Their deep penetration.
- 2d. Their freedom from rancidity.
- 3d. Their cleanliness of application.
- 4th. Their great economy.
- 5th. Their antiseptic and deodorant properties.

A long list of substances have been included in the oleate preparations.

Among the number may be mentioned copper, mercury, bismuth, zinc, etc. These preparations seemed to gain their popularity by the success achieved by an ointment of the oleate of copper in the treatment of ringworm. The oleate of copper is an excellent application in ring-

worm. The oleate of mercury would be indicated in the inunction treatment of syphilis, and in the various parasitic diseases. The oleate of bismuth would be useful in rosacea, and zinc oleate in vesicular eczema, and excessive sweating or hyperidrosis. Dr. Shoemaker, of Philadelphia, reports favorably on the use of the oleate of copper in the removal of freckles or lentigo, yet he does not claim that it is a specific for this disfigurement. It will be remembered that Dr. Shoemaker is an enthusiastic advocate of the treatment of skin diseases by the oleates. Whether the oleate of copper will prove itself a better remedy in lentigo than a solution of corrosive sublimate remains for the future to decide. There is no question but that the oleates are a valuable addition to the therapeutics of skin diseases.

At the recent meeting of the Pennsylvania State Medical Society, held the last week in May, Dr. Shoemaker spoke of medicated soaps. Potash and soda soaps are medicated with tar, naphthol, carbolic acid, salicylic acid, sulphur, balsam of Peru, alum, camphor, eucalyptol, corrosive sublimate, etc. They must be used with caution, as they are productive of harm as well as good, and they should not be relied on exclusively.

Dr. Engelsted, of Copenhagen, Denmark, made a report some time ago in regard to the use of naphthol in skin diseases. This remedy was first proposed by Kaposi, of Vienna, as a remedy in scabies. Kaposi recommended an ointment composed of fifteen parts of naphthol, ten of of chalk, fifty of green soap, and one hundred of lard. The results reported by various dermatologists do not correspond, as might be supposed. Engelsted is not inclined to regard it with much favor, except, possibly in scabies, while Van Harlingen, of Philadelphia, is especially pleased with its action in scabies, and regards it as a valuable addition to the external treatment of psoriasis. In eczema, seborrhœa, and ring-worm, he has not obtained the brilliant results claimed by Kaposi. In psoriasis it is used in the proportion of forty-five parts of naphthol, one hundred of water, and two hundred of alcohol. This solution is applied to the scaly portions of the disease morning and evening. It cannot be used many days at a time on account of the irritation it produces. Engelsted does not consider it as valuable as chrysarobin in the treatment of psoriasis. It is useful in a weak solution to allay itching.

Dr. Corlett, of Cleveland, O., recommends bromide of arsenic internally, and chrysarobin pigment externally in psoriasis.

Dr. George Henry Fox, in the second edition of his "Photographic Illustrations of Skin Diseases," speaks of a combination of chrysarobin, salicylic acid, ether, and collodion for the external treatment of psoriasis. The formula which he advises is as follows:

Chrysarobin	10 parts.
Salicylic acid.....	10 “
Ether	15 “
Flexible collodion....	to 100 “

This combination is known at the New York Skin and Cancer Hospital as the “Compound Chrysarobin Pigment.” Dr. Fox speaks very highly of this treatment. Chrysophanic acid causes more staining of the integument, and sometimes excites a pretty severe dermatitis, besides injuring clothing. This combination of chrysarobin does not produce these unpleasant effects.

Dr. H. G. Piffard, of New York, recently recommended bromide of arsenic in doses varying from one one-hundredth to one-fiftieth of a grain, two or three times a day, in *acne vulgaris*.

Dr. Morrow presented a case of *eczema* of the leg at a meeting of the New York Dermatological Society, February 26, 1884, treated with medicated gelatin plaster. The following formula was used:

Glycerin	250 parts.
Gelatin.....	1000 “
Water.....	2000 “

This was medicated with ten per cent of oxide of zinc and one per cent of carbolic acid. This was applied to the diseased skin, and allowed to remain a number of days. It forms a firm, protective coating, and retains the medicinal application evenly in contact with the disease. Another way of preparing plasters is to spread a coating of the medicated gelatin or other combination on muslin. The muslin can then be cut in any desired shape, and made to fit any inequality of the surface.

Dr. W. T. Alexander, of New York, recently called attention to the success he had met with in treating ringworm of the scalp, in a public institution, by the use of a ten-per-cent solution of chrysarobin in liquor gutta-percha. This pigment was painted over the diseased ring with a brush, and allowed to remain a number of days.

Within the past year, a mode of preparing medicated powders for moist skin affections was brought to the notice of American dermatologists by Dr. Faithful, of Australia. The remedy is first dissolved in alcohol, ether, or chloroform. The solution is then mixed with starch or French chalk, and the alcohol, chloroform, or ether allowed to evaporate. The evaporation should be conducted without the aid of heat. A fine medicated starch or chalk-powder remains. Various remedies may be prepared in this way. Vesicular *eczema*, *intertrigo*, herpes, ulcers, etc., may be treated with these powders. “Anderson’s Dusting Powder,” an old, but valuable remedy, is useful in the same conditions. This powder is composed of one-half ounce of zinc oxide, one drachm and a half of camphor, and one ounce of starch.

The somewhat remarkable statement has been made that a crop of warts has been removed from the hands by daily ten-grain doses of calcined magnesia, taken in the morning before breakfast. It has the merit of being harmless and simple, but I doubt very much the efficacy of the treatment.

Alder Smith recommends seven grains of chrysophanic acid to one ounce of chloroform in the treatment of ringworm.

Resorcin, a preparation from various gum resins, has been recommended in eczema, erysipelas, ulcers, wounds, and epithelioma. It is used in the proportion of one or two parts to ten of vaseline. It has not been used very extensively, and does not seem to have proven itself a very valuable addition to the therapeutics of the diseases mentioned.

Dr. R. W. Taylor, of New York, recommended a measure, last year, in the treatment of eczema marginatum, and of ringworm in general, of using a solution of corrosive sublimate in tincture of myrrh, or compound tincture of benzoin. Two to four grains to the ounce is the strength used. It is perhaps as well to commence with the weaker solution. The principle of using the benzoin or any of the gum resins is to furnish a vehicle for retaining the corrosive sublimate in contact with the diseased patch of skin. It is not thought that the tinctures have any therapeutic effect on the disease.

Dr. S. Sherwell, of Brooklyn, read a paper before the annual meeting of the American Dermatological Association, in August, 1884, on the treatment of acne and rosacea in the male subject. He made the basis of his remarks some old chronic cases of acne and rosacea. They had resisted every plan of treatment. They were finally relieved of the disease and its annoying disfigurement, by the introduction of the cold steel sound. The sound was passed every third day for a time, gradually increasing the interval to once a week, as improvement followed.

At a meeting of the New York Dermatological Society, held March 24th, 1885, Dr. George Henry Fox made some remarks concerning the balsam of Peru, combined with the various metallic oxides, as an adhesive dressing in skin diseases. Zinc, bismuth, magnesia, etc., may be thus combined. He also spoke of the treatment of psoriasis by salicylic acid in castor oil. Two to five per cent is the strength ordinarily used.

In the April number of the *JOURNAL OF CUTANEOUS AND VENEREAL DISEASES* for this year, is a note from Dr. Greene, of Christiania, recommending iodide of potassium in fifteen-grain doses three or four times a day, gradually increasing it, for psoriasis.

Pyrogallie and salicylic acids have been recommended in the treatment of chancre and venereal ulcers. Of the two, the pyrogallie has the greater weight of evidence in its favor, as being more prompt and

certain in action. It should not be combined with soap or other alkali, as it is thus readily decomposed.

Calx sulphurata, an article brought into prominence about fourteen years ago by Dr. Sydney Ringer, as a remedy in furuncles, is of value in other skin affections. Cane reported favorable results from its use, in 1878, in acne, and in eczema rubrum.

One of the latest remedies for psoriasis is the fluid extract of burdock seed. It is recommended in the doses of twenty drops to one drachm three times a day. I have used it with apparent benefit, but I have not had an opportunity of testing it sufficiently to be able to report intelligently in regard to it. It has been spoken of favorably by a number of physicians, yet it does not seem to have gained the confidence of those who know the most of dermatology.

Dr. E. L. Keyes, of New York, read a paper before the New York Dermatological Society, the first of this year, entitled "Note on Hydrochlorate of Cocaine—Its Possible Dermatological Uses." Briefly, it is recommended in cutting out small tumors, opening abscesses, in epilation, applying caustic to syphilitic sores, etc. There is no doubt but that it can be used to good advantage in many skin affections.

I wish to say a few words in regard to *phytolacca decandra*. It is well known that this remedy possesses the remarkable power of arresting glandular inflammation, especially of the *mammæ*. The thought has occurred to me, of late, that it might prove advantageous in acne, and possibly in comedo and seborrhœa. I have not had occasion to try it as yet, but intend to give it a trial at the first opportunity. It may not be of any value, but a thorough test of it would do no harm.

Selections.

THE PATHOLOGY OF RODENT ULCER.

WRITINGS on the microscopic characters of rodent ulcer may be said to have originated in the well-known monograph by Thiersch, on epithelial cancer, published in 1865. Anterior to this, the clinical features of the disease had been very carefully studied and described by Jacob, Paget, Hutchinson, and Lebert; and though they recognized its distinct identity as an infiltrating and ulcerating growth of a specific nature, a better knowledge of its minute structure was required to avoid the very natural difficulty of confounding it with lupus, syphilis, tuberculosis, or epithelioma. Thiersch's contribution is in every way worthy of the position which it occupies, and the illustrations accompanying the text show the author's clear conception of the histological features of this disease, which he

described as flat epithelial cancer, in contradistinction to the ordinary infiltrating form of epithelioma. Though regarding rodent ulcer as a variety of epithelioma, his researches encourage the opinion that it has a special origin in the sebaceous glands. Other observers soon followed, and their writings are without exception the result of careful and thorough investigation, becoming more and more valuable as the work of the microscope has become more and more perfect. In 1867, Mr. Moore, of the Middlesex Hospital, published his pamphlet, in which he described rodent ulcer as a form of epithelioma. In 1871 and 1873, Mr. Hulke expressed similar views at the Pathological Society. In 1872, Dr. Collins Warren, in his Boylstonian prize essay, maintained the opinion that the growth commenced in a small-cell exudation, which developed under the influence of the rete Malpighii; this, of course, must be regarded as a variety of the epithelioma view. In 1878 and 1879, Dr. Thin, at the Pathological Society, originated and supported what has since been called the sweat-gland theory. In 1879, Drs. Tilbury and Calcott Fox, at the same Society, read their paper in support of the opinion that the growth started in the root-sheath of the hairs; Mr. Butlin, in the discussion which followed, supported the sebaceous gland theory of Thiersch. In 1882, Dr. Sangster, at the annual meeting of the British Medical Association, read a paper also in support of the root-sheath view; and an additional paper, tending in the same direction, has since been published in the *British Medical Journal*, by Mr. Hume, of Newcastle.

There has then been a considerable diversity of opinion concerning the true nature of rodent ulcer, since the appearance of the writings of Thiersch. They may be classified as follows:

1. As a variety of epithelioma—Moore, Hulke, Collins Warren; and as depending upon the nature of the soil in which it grows—Hutchinson.
2. As a carcinoma of the sebaceous glands—Thiersch, Butlin, and others.
3. As a carcinoma of the sweat glands—Thin.
4. As a carcinoma of the hair-follicles—Tilbury and Calcott Fox, Sangster, and Hume.

The present communication is based upon the microscopic examination of twenty-two cases, in all of which the entire growth has been excised with the knife, and placed in my hands for investigation. Twenty of them were clinically unmistakable, the other two were doubtful. A few more cases of chronic epithelioma of the hand were clinically regarded as allied to rodent ulcer; but, since their structure is distinctly epitheliomatous, they are not included, though it is quite possible that they have equal claims to be. It would occupy too much space to describe the cases individually; and I shall, therefore, be content with generalizing some of the broader clinical facts, asking that the diagnosis may be accepted as correct, on the ground of the clinical experience of the observers, confirmed, if you will, by a personal examination of the specimens, as there are microscopical preparations here from every one of the cases.¹

The strange observation that rodent ulcer is, with very rare exceptions, limited to the face, is borne out by these cases, as all occurred in the skin of the face. Seven were on the cheeks; seven on the eyelids (the two doubtful ones both on the upper eyelid); three on the forehead; three on the side of the nose; and two

¹ The specimens, which were shown in the Section of Pathology at the annual meeting of the Association in Belfast, were obtained as follows: five from Mr. Bickersteth; two from Mr. Reginald Harrison; two from Mr. Mitchell Banks; three from Mr. Rushton Parker; two from Mr. Shadford Walker; two from Mr. Edgar Browne; one from Mr. Puzey; one from Dr. Little, and four were my own.

in the skin of the lips, one the upper and the other the lower, but both quite away from the red border. Sixteen occurred in males and six in females, bearing out the general opinion that the disease is more common in men than in women. The average age of commencement was 50, varying from 35 to 72; the earliest cases being in women. The great length of time occupied by an ordinary rodent ulcer in attaining a sufficient degree of severity to awaken any apprehension in the class of people who are usually attacked by it, is such as to mislead us to a certain extent as to the age when it commences; and I am sure that it ought not to be regarded as a very uncommon occurrence in the fourth decade of life. The average duration of the disease before operation was six years, varying from six months to fourteen years. This fact is, of course, of no great value, as the disease varied proportionally in extent, except that it is in accordance with the usual experience of the chronic nature of the growth. Those ulcers which were of short duration were small, shallow sores, covered with a scab, and showing the characteristic pale raised border of infiltration; while in one case the growth was a mostly subcutaneous nodule in the loose skin of the lower eyelid. The older growths had all the usual rodent characters, destroying the skin, muscle, eye, bone, etc., just as they happened to fall within the area of infiltration.

The specimens have generally, and always recently, been prepared by hardening the tissue in bichromate of ammonia, and subsequently in spirit; the sections have been cut by Bevan Lewis's microtome, stained in logwood and eosin, and mounted in Farrant's solution. The sections have, of course, always been taken through the growing margin into the surrounding skin, which has in all cases been carefully examined.

It is not necessary, at the present time, to say anything in reference to the purely carcinomatous type of the disease; that is admitted on all hands. I have, therefore, directed my attention entirely towards elucidating to what variety of carcinoma rodent ulcer belongs; or, in other words, of what epithelial tissue it is an atypical form. In some cancers this is a point which is easily decided; for instance, in epithelioma, cylindrical epithelioma, and some thyroid, hepatic, and other cancers. In others, it is equally difficult. Take, for example, an ordinary scirrhus of the breast. This is so mildly typical of breast-tissue, that most pathologists, even now, regard a scirrhus of the breast as a type of cancer which may occur at any part of the body, when it cannot possibly bear any other relation to a primary cancer of another organ, than that they are all epithelial new growths.

Rodent ulcer also is so slightly typical of any epithelial cutaneous structure—or, rather, it is so liable to show relationship with all the dermal epithelial evolutions, that great difficulty is met with in attempting to class satisfactorily.

It being accepted that rodent ulcer is a carcinoma of the skin, we have to decide whether it must be regarded as a carcinoma of the entire skin, or only of one of the dermal appendages; and if the latter, whether it is always an atypical growth of the same appendage, or whether it should be subdivided into carcinoma of each variety of appendage. With these difficult questions in view, I propose to consider:

1. The minute structure of the growth;
2. What normal skin elements, or other skin-growths, show any relationship to this;
3. Whether it has any special affinity for, or tendency to spread in one particular skin-structure rather than the rest;

4. Whether its remarkable localization to the skin of the face bears upon its origin;

5. Whether any microscopical evidence can be obtained as to its earliest formation—that is, the primary growth, not the marginal increase.

1. *The Minute Structure of Rodent Ulcer*.—Carcinoma, in whatever organ it develops, is liable to vary in its minute structure. In one typical form, the epithelial elements are arranged in acinous groups; in the other in duct-like columns of cells. The former is usually designated acinous cancer, the latter tubular cancer; and although, for purposes of classification, it is convenient to make this a clear distinction, it is really only an artificial one. For instance, in a series of cases of cancer of the breast, I find a large majority of specimens of acinous cancer, and very few of pure duct-cancer, and an intermediate group passing from one to the other. The same condition certainly holds good in carcinoma of the liver and prostate, and probably of all other acinous glands; but in strictly speaking tubular glands, such as those of the intestine, the carcinoma is almost constantly tubular. It seems not unlikely that this difference in structure depends upon the degree of evolution attained by the carcinoma under examination. A tubular growth is more embryonic than one that has attained to an acinous development. Thus a tubular epithelioma is one which consists solely of epithelial cells, resembling those of the rete mucosum. An acinous epithelioma, on the contrary, shows horny and nested cells—that is, the highest evolution of epidermal cells. A duct-cancer of the breast resembles the immature tissue of the virgin gland, an acinous cancer the fully developed organ of pregnancy. Rodent ulcer follows this general direction. It is sometimes absolutely tubular, sometimes transitional, frequently entirely acinous. Taking the two extremes, it is difficult to recognize them as being the same class of growth, but the chain of intermediate cases is so complete as to leave no doubt of their association.

Beginning in the skin, the various forms of rodent ulcer extend, after the manner of epithelioma, in all the elements of the skin itself, and in all the adjacent tissues; avoiding only that which is so readily infected by other kinds of carcinoma, namely, the lymphatic system. In the acinous variety, the groups of cells are strikingly disposed like those of epithelioma; and also like them, the marginal cells are cubical or cylindrical, and placed vertically upon the surrounding layer of connective tissue. The bulk of each acinus is made up of elongated cells, often very irregularly arranged; their disposition has been very aptly described by Sangster as though disturbed by opposing currents. Those which are next to the marginal layer have frequently their long diameters disposed at right angles to the cylindrical cells; but there is no constancy in their manner of arrangement, nor indeed in their character as cells. The marginal cells are usually epithelial-like, smaller and more delicate than those of the rete Malpighii, or of an epithelioma, but distinctly the same variety; whereas the intermediate cells are very sarcoma-like, or remind one very strongly of the spindle-shaped cells in an embryonic hair-bulb. Frequently, however, they are rounded or irregular in shape, but always much smaller than in epithelioma. The central portion of the acinus is yet more variable. Very large acini usually contain only a little central *débris*, which falls out in the section; others are filled with a delicate mucous tissue very poor in cells; and the remainder—no inconsiderable number of the whole—with nested cells; nested cells which are sometimes the result of a central aggregation of degenerated cells, unstainable, and therefore forming soapy-looking pseudo-pearls; or the result of endogenous multiplication, when the cells are

large, epithelial-like, and stain brightly. In size, the acini are often the equivalent of those of sebaceous glands, sometimes they are smaller than this, often many times larger. The central structure, when myxomatous, not unfrequently breaks up the mass of the acinus into a network of epithelial cells supported by mucous stroma. I have specially noticed this in deep infiltrations in the orbit.

Tubular rodent ulcer is far less common than the acinous variety. Perhaps it is never absolutely pure, though occasionally the structure appears almost uniform throughout. The most pure tubular structure was met with in a very small rodent ulcer of the nose. It consisted of columns of cubical cells, in some parts almost exactly like a sweat-gland; in others the lumen was filled with spindle-cells, which here and there so distended the tubes as to resemble an acinous development; but there was no central aggregation of cells into a pseudo-pearl, nor any central *débris*, nor other specialized tissue. The intermediate cases resembled generally the acinous variety, but in some parts fell off into a more or less perfect tubular structure. In no variety of rodent ulcer can the epithelial cells be said to attain to a distinctly horny character, nor to show the typical prickles of the cells of the rete mucosum like epithelioma; but the occurrence of nested cells is certainly not uncommon.

In addition to what may be called the normal varieties of rodent ulcer, the twenty-two cases include two distinctly aberrant forms of growth; one occurred in the upper lip of a woman, aged 58, quite away from the red border, as a thick infiltration, ulcerated in the centre. It had existed three years, and was considered by Mr. Bickersteth to be a rodent ulcer. Throughout almost the whole of the growth, the infiltration consisted of large spherical acini of uniform appearance, almost touching each other; each acinus consisted of a marginal layer of elongated cells, all the remainder being composed of similar round sarcoma-like cells, giving the microscopic appearance quite a different effect from ordinary rodent ulcer. An exact counterpart of this structure was met with in a multiple adenoma of the sweat-glands of the face; and I should have considered it to be an ulcerated adenoma, had not I found, near the ulcerated margin, a marked reversion to the ordinary type of rodent ulcer. The other aberrant case occurred in a man, aged 63, as an ulcer perforating into the nasal cavity, and it also had an unusually thick border of infiltration. It had existed for twelve or fourteen years and was regarded by Mr. Bickersteth as an undoubted rodent ulcer. Here the cells were like the rete mucosum, the only case in which this was noticed; but, instead of being arranged as in epithelioma, they formed very long straight columns, of only one or two cells deep, penetrating far into the subcutaneous tissue, and perfectly uniform throughout the whole growth. This might be called a tubular epithelioma, if regarded entirely from the histological point of view; but clinically, it could only be spoken of as a rodent ulcer, and, until the minute anatomy of the growth is more clearly recognized than at present, the clinical features have the first claim in establishing a diagnosis.

In the foregoing description of the minute structure observed in a number of cases of rodent ulcer, it has been easy to describe the remarkable variability of the growth, and the different types and characters to be met with; no doubt, it reads as though few cases resembled each other, nor do they entirely, but there is a subtle, almost indescribable, uniformity of type traversing most of these varieties, which enables a practised histologist to at once recognize the nature of the growth under the microscope.

As in all other new growths, every variety of rodent ulcer extends in mutual

relationship with a small-cell infiltration; but whatever interdependence exists is capable of a temporary abrogation; and, quite in conformity with the chronic character of the growth, the small-cell infiltration may develop into normal granulation-tissue over the surface of the sore, and may, for the time, allow cicatrization, although it is invariably followed very shortly by a renewed activity on the part of the epithelial elements, at the margin and base of the growth.

2. *What normal Skin-Elements or other Skin-Growths show a Relationship with Rodent Ulcer?*—Innocent epithelial growths usually closely resemble the tissue in which they grow. For instance, an adenoma of the breast, or a papilloma of the skin, shows the same relationship with the parent-tissue that we observe in the case of innocent connective tissue growths, such as lipoma, exostosis, fibroma, myxoma, etc. In the same way, malignant epithelial tumors are stamped with the nature of the parent-tissue, though on account of their imperfect development, they never attain to the precision of structure met with in the innocent tumors. This resemblance of carcinoma to the organ in which it originates is much more striking than is generally admitted, or even supposed. It is such that the tumor can very frequently be referred to the parent-organ through its structural similarity; and I have met with numerous examples, apart from epithelioma, and cylindrical epithelioma, of cancers of the breast, liver, prostate, kidney, nasal mucous membrane, thyroid body, etc., in which any one could at once recognize their special identity. But the evolution of carcinoma is commonly imperfect; and, in the embryonic stages, no one can gather sufficient information from the appearance presented by the malignant tissue to indicate its identity with the normal tissue. An absolutely embryonic condition of the growth is not likely to pervade the whole tumor, nor to be marked in many consecutive cases; so that, in taking a considerable group of any one class of new growths, we may feel pretty sure that the parent-tissue will be distinctly indicated in some of them, even though the indication may very likely have to be traced through the known structural evolution of that parent-tissue.

It is unfortunate that, amongst all the carcinomata, rodent ulcer shows the least striking resemblance of any of them to a normal tissue, and what resemblance is to be traced is not constant. For instance, while one specimen may show a tubular structure, and be referred to the sweat-glands, another has cells of a character and arrangement which point towards an affinity for hair-follicles. The resemblance in the former case, when present, is marked, but in the latter can only be traced through the character of the cells forming the acini; thus, the marginal layer resembles the columnar cells of the root-sheath more than those of the rete mucosum, while the spindle-shape and whorled arrangement of the intermediate cells may indicate an abortive attempt towards the development of embryonic hair-bulbs. Sebaceous glands being only diverticula from hair-follicles, it seems probable that any cancerous development related specially to them would be a variety of the hair-follicle type of growth. The large fatty pseudo-pearls sometimes met with in rodent ulcer may mean a sebaceous transformation of the central cells of the acini. The only other epithelial tissue of the skin is the epidermis itself, the atypical formation of which is, without question, epithelioma; and that there are cases of epithelioma which have the clinical characters of rodent ulcer, such as chronic growth, rodent ulceration, and absence of glandular infection, every one must admit. At present, such cases are only distinguished from the rest after a microscopical examination; but it is questionable whether the clinical line of demarcation between epithelioma and rodent ulcer

is not more correct than an artificial separation based entirely upon minute structure. I was prepared to rely more upon a relationship between the minute structure of rodent ulcer and some normal skin-element than upon any other point, in determining its origin; but a very careful and impartial examination of these twenty-two cases has led me to the conclusion that, if it can be said to be an atypical formation of any epithelial cutaneous tissue, it must be regarded as being equally associated with all the dermal appendages, and I think that it is. Apart, then, from other considerations, there are some grounds for assuming—though they are less clear than in other varieties of carcinoma—that, on this account, rodent ulcer may be described as a chronic carcinoma of the skin, showing very abortive attempts in its evolution towards the development of the dermal appendages.

Innocent glandular growths in the skin are not of common occurrence. It is not without importance that they are met with, like rodent ulcer, almost exclusively upon the face, with the exception of some sebaceous formations which do not belong to the class of adenoma. My own experience is limited to six examples of solid glandular tumors in the skin; one multiple, occurring all over the face and spreading into the scalp, one near the eyebrow, two on the cheek, one on the nose, and one in the scalp. In only the first could the distinct origin of the growth be traced. The patient was under the care of Mr. Rushton Parker, and he removed a large cluster of tumors from the forehead, together with the skin to which they were attached. In the latter, microscopic tumors were found which clearly showed that the primary changes occurred in the sweat-glands. A young growth consisted of spherical acini of small round cells with bright nuclei and indistinct cell-wall, and a marginal layer of elongated cells. The acini were surrounded by a fairly distinct basement-membrane, and were separated by very little connective tissue. Between them duct-like structures were seen at intervals, lined with cubical epithelium, and also portions of sweat-glands. In older growths, many of the cells had undergone a sort of colloid change, which had quite a clear fatty appearance, but was unaffected by osmic acid. This is the case of adenoma, which has been alluded to as being exactly like the infiltration in one of the cases of rodent ulcer. It strongly confirms the relationship with sweat-gland tissue, which is indicated by the structure of the tubular variety. One at least of the remaining cases of adenoma, a tumor of the cheek of twenty-five years' duration, is certainly based upon similar structure; but the others, which were of more recent growth, consisted of epithelial cells, infiltrating a myxomatous matrix, and reminded one strongly of the familiar adenomyxoma of the parotid. Whether these adenomas originated in sweat or sebaceous glands I cannot tell, the one from the scalp was certainly thought to be of sebaceous origin; but be this as it may, they are all very much like the deep infiltration of rodent ulcer, which has been referred to as a network of cells in a mucous stroma, so much like, indeed, that, in many parts, one cannot be distinguished from the other.

3. *Has Rodent Ulcer any Special Affinity for, or any Special Tendency to spread in one Skin Structure more than Another?*—Much stress has been laid by all recent writers upon observations intended to determine the mode of growth of rodent ulcer, particularly in reference to its tendency to infiltrate certain epithelial skin structures; and having decided which structure is most commonly affected, they have at once concluded that the primary growth originated in a similar tissue. Thus, one investigator finds that changes are to be observed in surrounding hair-follicles, and concludes from this that rodent ulcer is a carcin-

noma of the hair-follicles. Others hold similar opinions, based upon similar grounds, respecting the sebaceous and sweat-glands. But even though rodent ulcer does involve these structures, and it certainly does, the fact really proves nothing as to its origin. An epithelial growth may always implicate neighboring epithelium, and though a primary cancer of a glandular organ often shows a special tendency to convert the epithelium of that organ, yet its normal mode of extension is entirely independent of it; while it is also true that a secondary growth may possess the same influence on the gland-epithelial. The mode of increase throws no light upon the minute origin of rodent ulcer, and, as a matter of fact, when a sufficient number of examples are examined, it soon becomes apparent that the growth, in its extension, constantly involves all the dermal appendages, one as much as another, but not all of them put together one-tenth not one-hundredth part as much as the usual mode of growth in the connective-tissue spaces of the skin, in relationship with a small-cell infiltration. Exactly the same holds good of epithelioma. I have specimens in which it infiltrates sweat and sebaceous glands and hair-follicles; but this does not affect its undoubted origin in connection with the rete mucosum, though it is no unusual thing to find this latter—here admittedly the parent tissue—lying in close proximity to the growth, and yet affected by it in no way, except perhaps by pressure.

4. *The Localization of Rodent Ulcer to the Skin of the Face.*—The disease is probably not entirely localized to the face, but it is a remarkable fact that sores of the same clinical characters elsewhere, have almost, without exception, a genuinely epitheliomatous microscopic structure. The adenomata of the skin appear to be very much limited to the same region, while papilloma, like epithelioma, may be met with anywhere. If we had any reason to believe that the origin of rodent ulcer was connected specially with sebaceous glands, then their luxuriance in the skin of the nose and cheeks, and in the large Meibomian glands of the eyelids, might account for these parts being its favorite sites. But there is no sufficient reason to associate rodent ulcer with sebaceous or Meibomian glands, while the usual adenoma of these situations is probably of sweat-gland origin. However, the localization of rodent ulcer and skin adenomata of the face is, to my mind, the strongest piece of evidence that I have met with in favor of associating the origin of the former with the glands of the skin.

5. *Is it possible to obtain Microscopic Evidence of the Commencement of a Rodent Ulcer?*—Somehow or other, it seems to be taken for granted that the first step in the direction of the formation of a new growth involves only the most minute area of tissue, and that, therefore, a rodent ulcer in the first instance is evolved from a single gland or hair-follicle, and not from an appreciable tract of skin. On the other hand, the areas of irritation, which we are justified in regarding as the source of some other new growths, appear to undergo a malignant transformation over a space much more than microscopic from the first. An ordinary epithelioma, or a sarcoma following injury, might either of them be taken as examples. We are so much in the habit of regarding epithelial developments as budding from germs that it seems only rational to suppose that a carcinoma has budded from some little spot that is diseased, perhaps from only a single cell. But as far as we know it, the first stage of every post-embryonic new growth is a condition of irritation and inflammation; a condition which may remain unaltered for an indefinite length of time, and which, but for some specific influence, might have returned to a normal state, though under this influence it becomes transformed into an innocent or a malignant growth. The primary tract of irritation, however, in both its simple and its transformed conditions

involves an appreciable area of tissue of a size, I have no doubt, large enough to be capable of occasional detection and examination in all the stages of its existence.

The microscopic changes which take place during the transition from subordinate inflammation to independent new growth in a tract of irritated tissue can be only a part, and an insignificant part, too, of the whole story; unless, indeed, the presence of a pathogenic organism were to be revealed, which is perhaps improbable. It is, however, quite worth while working out the steps in the transformation as far as they can be seen with the microscope; and it is at least of much importance to be able to identify them, as far as may be, with the normal processes of inflammation and growth. This much seems to me to be clear, that all post-embryonic new growths have a common origin, of the nature of inflammation; that their subdivision into innocent and malignant tumors depends upon the specific infecting or non-infecting character of the inflammation; and that their mature structure develops entirely under the influence of the tissue first affected, so that the tumor is always an imperfect edition of the parent-tissue. Now it is supposed that, if the skin as a whole suffer a chronic irritation, such as that produced by soot or a clay pipe, in certain people the rete mucosum will take on an independent growth, resulting in an epithelioma; but that if the primary irritation affected only a sweat-gland, hair-follicle, or sebaceous gland, the growth would be a rodent ulcer. That an epithelioma commences in an irritation of a patch of skin or mucous membrane is undoubted; it remains, however, an open question whether rodent ulcer has a more limited origin.

In dealing with specimens of pre-cancerous formation in the skin, it is, of course, impossible to be certain as to the correctness of the diagnosis; but surgeons of large experience not unfrequently excise conditions of warty or other alterations in the skin which have become irritable, because, in their opinion, such a state may go on to the development of a carcinoma. It is very probable that, in such cases, the opinion is often correctly formed, and sometimes it is proved to be so by the earliest cancerous changes having actually commenced. I have had several times the opportunity of examining such portions of skin, and the microscopic changes present in them have been uniform and simple. There is an area of increased vascularity, over which a dense infiltration with inflammatory cells is seen, placed just beneath the epithelium. The latter is thickened, the superficial cells being piled up in warty form. The cells of the rete mucosum are evidently undergoing rapid multiplication, the lower layers being often crowded and sometimes appearing as a mass of nuclei. It seems, at this stage, as though the epithelial cells ceased to be able to pass upwards in normal rotation; and one finds instead that, throughout the area of warty thickening, there are buds of rete mucosum penetrating below what is still easily recognizable as the old line of the basement-membrane into the dense inflammatory infiltration, and then it seems as though the epithelial cells, being really the reproductive layer of the rete mucosum, and being now surrounded by an embryonic tissue, become independent, and henceforward grow with the characters of malignancy.

On only two occasions have I had the opportunity of examining tissue, which, it was supposed, might have become rodent ulcer; both were from the upper eyelid. One case was that of an old lady, in whom a small tract of warty growth appeared upon the upper eyelid, and was removed by Mr. Shadford Walker, because he considered it an early condition of rodent ulcer. It showed exactly the same pre-cancerous changes as have been described as occurring in epithelioma. The other occurred as a small papule on the edge of the upper eyelid of a gentleman

aged 47. It had been coming for years, and I snipped it off, as it was irritating the cornea, without excising a portion of the eyelid. The growth in this case was of the nature of a congenital mole; that is, the lymph-spaces of the connective tissue were full of epithelial-like cells, though he was not aware of its congenital origin. The base remains still in the eyelid, and will be excised and examined if independent growth at any time assert itself. The smallest rodent ulcers that I have examined, and some have been very small, even before ulceration had commenced, have yielded no evidence as to their minute origin, since, in all of them, the growth had gone entirely over to the cancerous stage. Under the head of minute origin, then, I have not much evidence to offer as to the primary changes in rodent ulcer; but what there is points in the direction of its probable origin in the skin as a whole, and does not tend to associate it with any particular dermal appendage.

While one follows with the microscope the visible changes which accompany the first steps in the formation of a new growth, one seeks, and seeks in vain for the presence of a motive power. Whether the excitant is engendered by a chronic irritation of the part, or whether it is only rendered locally active by it under certain constitutional conditions, are questions which remain at present unsolved. But the degree of evolution to which a new formation may attain, must plainly depend, to a large extent, upon the nature of this excitant. The more it resembles the normal stimulus to growth and development, the more perfect and limited will be the development of the new growth, as obtains in a fibroma or a papilloma. The more intense the excitant, the more embryonic and unlimited the growth, as in sarcoma and carcinoma. But if it may be that, in some cases, there are local or constitutional conditions, which can weaken the effect of the excitant, then it seems possible that what would otherwise have been an epithelioma, might become a rodent ulcer. For many reasons, I would have preferred to believe that rodent ulcer was a specific variety of carcinoma, and there is much to be said in favor of its association with the glands of the skin, but I am not at all clear that we have any evidence to show that the carcinoma of any anatomical region is susceptible of specific subdivisions in its origin, although it certainly may attain to very different degrees of evolution. For the subjoined reasons, I incline to regard rodent ulcer as a form of chronic carcinoma of the skin, rather than as a carcinoma of any special dermal appendage.

1. Because its structure varies greatly, and because in normal development the rete Malpighii produces very various epithelial structures.

2. Because there are to be seen appearances in the minute structure of certain rodent ulcers, which resemble some points in the evolution of the several dermal appendages.

3. Because, also, there are points of resemblance between certain rodent ulcers and the innocent epithelial growths of the skin.

4. Because the general arrangement and type of the growth is like a slow-growing epithelioma.

5. Because it passes insensibly into epithelioma.

6. Because its minute origin, so far as it can be surmised, is the same as in epithelioma.—PAUL, *Brit. Med. Journ.*, May 2, 1885.

A LECTURE ON THE TREATMENT ON RINGWORM.

HAVING, in the last lecture of this course, spoken of the origin of this disease of its being caused by the growth, in the skin, of the head of a vegetable fungus,

and of its symptoms, I have now to speak of its treatment. The principle of this treatment is perfectly simple; it consists in applying some substance which kills the fungus, the inflammation and other incidental changes in the skin being of minor importance. This method is, in principle, identical with that employed by gardeners to destroy parasitic fungi infesting plants, and even with that which is used in curing fungus-growth in dead materials, as, for instance, the dry rot of timber. Nevertheless, such are the difficulties of bringing parasiticide substances into actual contact with the ring-worm fungus, especially when it is situated in the hair-follicles, that the cure of this fungus-disease is, in some cases, one of the most difficult problems of practical therapeutics. It might be thought that the same results would be attained by rendering the soil unsuitable for the growth of the fungus, but this method is applicable only in a very limited degree. It is difficult to render the soil unfit for the parasite without destroying its vitality altogether. We can only, in certain cases, set up a special kind of inflammation the products of which are fatal to the fungous growth.

Before speaking of the actual methods of cure, we must for a moment consider a point which should always be thought of in the therapeutics of every disease; namely, what is the natural course of the disease? What happens if it be not treated at all? Is ringworm, for instance, an acute disease, like a specific fever, with a natural progress, acme, and termination? Or is it a disease, such as syphilis, chorea, or chlorosis, which has a long natural period of evolution, but still finally comes to an end of itself? Or is it strictly a chronic disease which has no natural tendency to terminate? Ringworm is certainly not an acute disease; but the question whether it has any natural or spontaneous termination is not so easily answered. The allied disease, favus, may certainly last a lifetime. We had at this hospital, some years ago, a family with favus of the scalp. The mother had acquired the disease when a child, had grown up and married, but was still in middle life, uncured. Her husband never caught the complaint, but her children, as they grew up, successively had it at various ages. Every one is not liable to take this disease; but, when once established, it has no natural tendency to get well, at least when it affects the head.

With ringworm, the case is somewhat different. This is never a lifelong disease, the reason being that the susceptibility to it at different ages is very different. Ringworm of the body may, indeed, occur at any time of life, but ringworm of the head is rarely found except in children. Infants, that is to say, up to three years old, do not very often acquire the disease, and when they do so, are easily cured, and the disease may even, perhaps, in them, die out spontaneously; but the period from four years up to the age of puberty is that of the greatest susceptibility.¹ During this time of life, if once acquired, it easily passes into a chronic condition, and may remain for weeks, months, and even years. The influence of idiosyncrasy is as marked here as in any other of the specific diseases, and consequently some children are more liable to this disease than others, and have it more severely. There may be cases in which the susceptibility may be very slight, and in which, therefore, the disease may die out spontaneously; but this, if it occur, is a very rare event. Generally, the child who is liable to the disease is not liable readily to lose it.

The only process which can be regarded as a natural method of cure, is one which I will now describe. Among many of the cases of ringworm, there are always some in which the accompanying inflammation is severe, and this inflam-

¹ Lately, however, two children, aged 5 and 6, were brought to the hospital, each of whom had had the disease since six months old.

mation may go on to suppuration. Each hair-follicle may be converted into a separate pustule, and there may be also diffuse infiltration of pus through the skin. The affected portion of the skin is swollen, intensely injected, and looks as if it were about to form an abscess; though, if an incision be made, there is found to be no single collection of pus, but rather a general infiltration. The hairs become loose, and either fall out or are easily removed. This condition is called "kerion," and was formerly thought to be a distinct disease, though now known to be only a form of ringworm. It is generally supposed to be the effect of too severe treatment, but it may occur when even the mildest applications are being used, and may, I believe, arise in cases which have not been treated at all. This is, at all events, true of ringworm of the beard or parasitic sycosis, in which deep and extensive suppuration is sometimes observed when no remedies whatever have been used. Now the remarkable fact is that, when the condition of kerion subsides, as it will do spontaneously, the disease at that particular part is cured, and a bald patch left, even though it may be making progress in other parts. Kerion, then, is a spontaneous method of cure, or, in the words of Sydenham, "an effort of nature to get rid of the morbid matter." Independently of this occurrence, the disease may spontaneously exhaust itself as children get older. It is said that at the age of puberty it always dies out. This, I dare say, is true; though, fortunately, I cannot say that I have ever observed a single case through a sufficient number of years to arrive at this conclusion from my own experience. It is, however, quite certain that, at or after fourteen or fifteen, children becomes less liable to the disease, and it is more easily cured.

Let me give you an instance in a family that came under my care more than ten years ago; there were six children, all in good health, when ringworm was introduced into the family. The eldest, a girl aged 17, caught the disease, but was easily cured in less than one month. The second girl, a year or two younger, did not take it. The third child, a boy of 13, took it, but was cured as easily as his elder sister. Next in the family came two girls—twins—at that time ten years old. In them the disease caused copious suppuration, in fact a condition of kerion, and both recovered after a few months. The youngest, a girl of 7, perhaps the healthiest of a very healthy family, took the disease at the same time, and, in spite of identical treatment, suffered from it for two years. All these children were treated, in the first instance, by a very experienced and careful medical man, and all in the same way.

Only last week I came across a similar instance. A boy, aged 9, was brought to me with ringworm, which he had had for five years. Five other children in the family had caught the complaint. One was cured in a fortnight; the others after longer but variable periods. One brother had had it, in a public school, for more than a year. Some of those who recovered were said to have had abscesses in the head, that is, kerion. The inveterate case brought to me was a perfectly healthy and robust boy, and the youngest of the family.

I believe you will often meet with the same experience in families. The elder children, if treated, soon recover; the younger have the disease more severely, but also recover, especially if there be suppuration. One case may, on the other hand, be far more obstinate than the rest, and this will generally be the youngest. There must be some special predisposition in these very obstinate cases, but it is extremely difficult to say on what this depends. It does not, I think, as is sometimes said, depend on a bad state of health. One of the children above mentioned was as healthy and robust a child as I have ever seen; and if any one were to put

forward the proposition that healthy children offer a more suitable soil for the fungus than those who are delicate, it would be very difficult to refute it.

Complexion and thickness of the hair seem to have some slight influence. Coarse, strong hair is less liable to be affected than that which is fine; black hair less than blond. Lately I had two sisters under my care, one fair-haired, the other dark. They have been treated in the same way, and the black-haired child is nearly well, while the other makes but little progress. But you will find many exceptions to this rule, if it be a rule; and in general no important predisposing influence can be traced, except that of age. Even this does not always hold, and it is quite impossible to account for the obstinacy of some inveterate cases. The practical conclusion which should be drawn is this, that the recovery of a considerable number of slight cases under any particular treatment is no proof that this method has any special efficacy beyond all others. On the other hand, we must not attribute the long duration of certain cases to any special fault in the treatment. These views, I may say, whatever their value, have been formed after more than thirteen years' experience in the charge of a hospital department, offering a large number of cases every year.

I will now speak of the treatment which we have to employ, and shall confine my remarks chiefly to ringworm of the head—*tinia tonsurans*—because ringworm of the body is far more easily cured; and, with regard to favus, this disease is so rare that it has little practical interest for us. Whatever remedy be employed, there are certain practical measures which should always be adopted.

1. Either shave or cut the hair off. In summer, and if the disease be at all extensive, shaving is better. The operation itself drags out many of the loose hairs, cleans the skin, and accelerates the cure. In winter, and in slight cases, cutting may be sufficient. Throughout the whole period of treatment, keep the hair cut quite short; at least, over the affected parts.

2. Let the head be washed thoroughly with soft soap. This rule has been sometimes objected to, and it has even been said that washing may spread the disease. Of this, however, there is no direct evidence, and it is in itself improbable. It will depend on the special mode of treatment adopted how often this washing has to be repeated.

3. Epilation, or pulling out the diseased hairs with forceps, is a valuable aid to all curative methods. This process was first introduced in Paris for the cure of favus, and is very systematically carried out at the St. Louis Hospital, where I carefully studied the cure of parasitic diseases in 1865. The method there used is, or was, to pull out all the hairs, sound or diseased, so as to render a small part of the scalp temporarily quite bald. The treatment is carried out for about half an hour at a time every two or three days. In the early stages of cure, either of favus or of *tinia tonsurans*, the hairs come out easily, and the operation gives little pain; but, as the disease progresses towards recovery, and the hairs become more firmly rooted, it is extremely painful. During the operation (and this is a most essential part of the treatment), the surface is kept wet with a solution of corrosive sublimate in water (about one grain to the ounce). In Paris, this operation is carried out by trained male hospital attendants, a class to which we have nothing corresponding; and the difficulty in English practice is to know by whom it shall be done. It is obvious that the medical man cannot generally do it himself, and he must, therefore, instruct the mother or the nurse in the art of epilation. The process is much less painful, and nearly equally efficacious (in ringworm, though not in favus), if it be confined to pulling out those hairs which,

being diseased, offer little resistance. This may be called the German method, as practised at Vienna.

With regard to the remedial substances employed, these are nearly all what we call parasiticide; but, in fact, most of them have been employed empirically for centuries. Before the existence of parasitic fungi was dreamt of, Bateman tells us that the ancients used sulphur, *atramentum sutorium* or blacking (that is, sulphate of iron), tar, soap, resin, vinegar, and other substances still in use. In the last century, tar and sulphur were generally used. The St. Thomas's Hospital Pharmacopœia in 1741 contained an ointment used for "scald-head," composed of tar-ointment and train-oil in equal parts. The St. Bartholomew's Pharmacopœia in 1739 has an ointment specially intended for tinea, and composed of tar, sulphur, and wax, "to be anointed once a day, the head being covered with a hog's bladder." In fact, the remedies of ancient and modern times are very similar, and may, for the most part, be arranged in the following classes: 1, metallic salts, especially those of mercury, but also of iron and copper; 2, sulphur, with which may be placed the more modern sulphurous acid; 3, aromatic and resinous substances, such as tar, oil of cade, creasote, and carbolic acid, and the compound produced by the action of iodine on tar, called Coster's paint; with these may be placed the modern remedy, chrysophanic acid or chrysarobin; 4, strong irritants, vesicants, or stimulants, such as strong acetic acid, cantharides, and croton-oil. The chief novelties in modern times are the introduction of certain chemical remedies, as borax and boracic acid, carbolic acid, and others, and also the use of mercury and copper salts in new forms. These remedies are dissolved in, or mixed with, certain materials which may be called "vehicles." These are water, glycerin, alcohol, chloroform or ether, fatty substances, and vaseline.

1. *Watery solutions* have only a limited application. We use solutions of borax, of the strength of from ten to thirty grains to the ounce, or of corrosive sublimate, one grain, or less, to the ounce. Sulphurous and acetic acids are also used in watery solution. All these lotions may conveniently have glycerin mixed with them, to prevent their drying up. The disadvantage of water as a vehicle is that it scarcely penetrates the skin at all, and these lotions are therefore useful chiefly for destroying free spores, or portions of fungus which may be scattered about on the surface. A watery solution of iron salt, in the form of ink, is a well-tried domestic remedy, and, no doubt, cures slight cases; so with the copper solution obtained by keeping a copper coin constantly wetted with vinegar. The list of metallic remedies might doubtless be enlarged.

2. *Glycerin* has been largely used in cases of ringworm, but has scarcely more penetrating power than water, and appears to me to be the least useful medium for applying local remedies. It has, however, one advantage; namely, that, in consequence, perhaps, of not being absorbed, it checks the absorption by the skin of poisonous substances, and hence we may use matters which would be injurious if absorbed with greater freedom when dissolved in glycerin than in any other medium. At one time, I used glycerin of carbolic acid a great deal, but have lately almost given it up.

3. *Alcohol*.—The advantage of alcoholic applications (which they share with chloroform and ether solutions) is that they remove much of the greasy matter which covers the skin, and which is always very abundant in ringworm. By so doing, they are thought to render the skin more permeable to the remedial agent; but, considering the hardening effect which alcohol has on all animal tissues, it is difficult to believe that it can favor absorption. Tincture of iodine is an useful alcoholic preparation, and more efficacious than liniment of iodine made with

water. It destroys the fungus so far as it can reach, and also, by causing desquamation of the epidermis, assists the penetration of other remedies. An alcoholic solution of boracic acid* has been strongly recommended by my friend, Dr. Cavafy, and, no doubt, it is useful, though I generally employ boracic acid in another form. Alcoholic solutions of tars are largely used by the Germans.

4. *Chloroform* and ether remove fatty matters from the skin much more completely than alcohol, and, since they quickly evaporate, can have little effect in hardening the epidermis. They have, therefore, chloroform especially, been much recommended of late years, and, no doubt, with good reason. I have used a mixture of chloroform and oil of eucalyptus, in equal parts, with great advantage. A chloroform solution of chrysophanic acid is also highly spoken of; but I cannot think that chloroform, as a vehicle, will permanently supersede that of which I shall next speak.

5. *Fats*, or especially lard, form the main constituent of all the ointments most generally used in the cure of ringworm. Of late years, objections have been brought against the use of any fatty substance for this purpose, on the ground that the skin is already loaded with natural fat, even to excess; but I cannot think that these objections outweigh the universal testimony to the usefulness of ointments in most affections of the skin. There is no doubt that fat, especially animal fat, penetrates the skin more thoroughly than any other medium that we can use. In so doing, it carries with it the parasiticide remedy, and brings it into contact with the fungus at considerable depths below the surface. No fact is more clearly proved than that remedial substances are thus carried by fat into the skin, and diffuse into the body generally. If, for instance, we want to get mercury absorbed for the sake of its constitutional effects, we rub it into the skin along with fat; and the only objection to using mercurial ointments for their local effects is that absorption takes place even too readily. I, therefore, believe that, notwithstanding all theoretical objections, we shall go on using ointments in the treatment of ringworm, at least for a long time to come. Of late years, a preparation of mercury has been brought into use which acts in the same way as an ointment, and has a great penetrating power, namely, oleate of mercury. This substance was first used by Mr. John Marshall, to produce constitutional effects, and is useful, locally, for the very reason that it is easily absorbed. Oleate of copper has been strongly recommended by Dr. Shoemaker. I have given it a trial at the Blackfriars Hospital for Skin Diseases, but find it less powerful than oleate of mercury.

6. *Vaseline*, paraffin, and similar heavy hydrocarbons have been much used lately as a substitute for lard in making ointments: they have the advantage of being unalterable, but have little penetrating power. Generally speaking, they possess no advantage over lard in the treatment of ringworm.

I will now give the formulæ for the ointments I am most in the habit of using in the treatment of ringworm, but do not claim for these any special efficacy. The same result may be attained by the use of a vast variety of similar mixtures containing the parasiticide substances above mentioned, if properly applied. In fact, we may say of all systems of treatment that the success depends more upon who applies the remedies than upon who prescribes them. Among mercurial substances, we use an ointment containing nitrate of mercury and creasote: R Ung. hyd. nit. ζ i.; creasoti \mathfrak{m} x.; adipem ad ζ i. M. Another, containing white precipitate and sulphur: R Ung. hyd. amm. ζ ii.; sulphuris gr. xv.; adipem ad ζ i. M. We also use oleate of mercury. This substance is sold in two strengths, one called five per cent, and the other ten per cent. These names correspond to

the proportions, not of the salt, but of the oxide used in preparing it. The five-per-cent oleate is an oily, semi-fluid substance, the ten-per-cent a rather firm ointment. Carbolic acid may be used in an ointment containing thirty or sixty grains to the ounce of either lard or vaseline. Boracic acid I use in the formula given by Mr. Martindale—paraffin (melting at 135° or 140°) 5, vaseline 15, boracic acid 4 parts.

I have lately employed a remedy which, I believe, has not been used before, namely, eucalyptus-oil, in an ointment made according to Martindale's formula: Paraffin, two ounces; vaseline, two ounces; oil of eucalyptus, one ounce.

I have also employed in a ointment made of lard, in the strength of one drachm to the ounce, and mixed with chloroform, as mentioned above. It is very useful in early cases, and I have seen already several cases cured by it; but it is not among the most powerful remedies.

I will now give you an outline of the course of treatment pursued, first, in a slight or early case, and then in more severe cases. In an early case, after removing the hair, and washing with soft soap (the latter operation should at first be repeated every day), we keep the surface of the head moistened, during the day, from time to time with a lotion; for example, boracis gr. xv., glycerini 3 i., aquæ 3 vij.; M.; or, hydrargyri perchloridi gr. i., glycerini 3 i., aquæ destillatæ 3 vij.; M.; or else, with glycerin of carbolic acid. At night, have one of the ointments above mentioned thoroughly rubbed in, and the head covered with a cap. This treatment, with lotion and ointment alternately, should be continued for two or three weeks, or longer, till the disease has definitely localized itself in particular patches on the scalp. After this, instead of lotions, paint the patches every three or four days with either a tincture of iodine or the remedy called "Coster's paint,"¹ continuing the ointment in the interval as before. By these means, a certain proportion of cases, perhaps one-half, or even two-thirds, will generally be cured in a few weeks, or at most a month or two. Should the case prove more obstinate, or should we have to treat a case where the disease has already existed for some time, we slightly modify the above treatment. In place of the painting with iodine, apply blistering-fluid occasionally, or use "Coster's paint" more frequently. Blisters are dangerous in infants, and should not generally be used in children under five years of age. In such a case, epilation should be very carefully and systematically carried out (taking care to warn the parents of the temporary baldness produced). If these means do not suffice, it will be well to change the ointment and use either a strong preparation of carbolic acid or oleate of mercury. In the circumstances here considered, washing should only be carried out about twice a week.

Should all these measures fail, and the case of ringworm be protracted more than six months, or should we be called upon to treat an inveterate case, an entirely different method is to be recommended. The best plan here will be to apply oleate of mercury, in the five-per-cent strength, by means of a sponge, mop over the whole of the head once a day, without removing that previously applied. The head should be covered with a flannel or linen cap, night and day, and should be washed once a fortnight only, or once a week at most. The result of this treatment usually is, that the skin becomes somewhat inflamed; and there is, at all events, considerable seborrhea, and the scalp becomes covered with scales. It is,

¹ Coster's paint, made according to the original formula (one part of iodine with four parts distilled oil of tar), is a chemical compound, not a mere solution, and contains little free iodine. It is not irritating, and appears to me to be the best of occasional applications; but it need not be used frequently, as it forms a crust.

in consequence, difficult to tell what progress the cure is making. Accordingly, after fourteen days of such treatment, omit the oleate, wash the head thoroughly, and use a milder application, such as boracic-acid ointment, till the skin is clean. We are then in a position to judge how far the disease is eradicated. If broken hairs and stumps still remain, we revert to the oleate treatment, and continue it for another fortnightly period; then clean off the scales as before. A certain amount of suppuration is no reason for stopping the oleate application; but the least soreness of the gums will make us, of course, discontinue it. I must, however, say that I have generally found some constitutional effect produced in those instances in which the oleate has effected a radical cure of the local disease. Cases which have lasted for years may often, by this means, be cured in as many months. I have spoken of some such in the last volume of the hospital reports (*St. Thomas's Hospital Reports*, vol. xiii., p. 325).

If even this treatment fail, there is one yet more severe, namely, the production of artificial suppuration, or *kerion*. I will not describe this at length, but refer to Dr. Alder Smith's valuable little book on "Ringworm." It is, I think, efficacious, but is very painful and somewhat dangerous. Hence it is, I think, less used than it was a few years ago. With regard to the constitutional treatment of ringworm, I have already said that I think the state of health has little to do with the persistence of the disease. Nevertheless, a change of air, removing the patient from the influences surrounding him at home, often appears to be of great benefit. I should always recommend that, in a very tedious case, the room in which the child sleeps, and the bedding, should be disinfected as carefully as in the case of any other infectious disease. These precautions have in some cases appeared to arrest the disease, which was being treated in vain by local remedies.

With regard to ringworm of the skin (*tinea circinata*), its cure is conducted on the same principles as that of *tinea tonsurans*, but is much easier. The patches should be well painted with tincture of iodine, which is sometimes sufficient. If it should not be, wash thoroughly with soft soap, and apply one of the parasiticide ointments above mentioned. Most cases will be cured in a fortnight.

Ringworm of the beard (*parasitic sycosis*) has become rather more common in London, of late years, than it used to be. It is treated in the same way as other forms of ringworm; but the amount of inflammation is sometimes so great that cooling remedies, especially lead-lotion, have to be used at first. Poultices are better avoided. In the next place, painting with iodine (if the patient do not object) is very useful, both to counteract the deep-lying inflammation and to kill the fungus. In order to effect a cure, carefully eradicate the diseased hairs, and rub in one of the parasiticide ointments. The cure is sometimes tedious, but less so than in a really bad case of ringworm of the scalp.¹—J. F. PAYNE, *Brit. Med. Journ.*, May 23, 1885.

¹ A pure form of oleate of mercury has recently been introduced, which produces no inflammation or seborrhœa. In spite of this advantage, it has seemed, in hospital practice, less efficacious than the impure five-per-cent oleate.

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THE TREATMENT OF ERYSIPELAS.

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THE treatment of what has usually been termed idiopathic facial erysipelas, notwithstanding the numerous specifics which have been recommended, is of interest both on account of the frequency of the disease, and the failure of the usual means to control it, in many cases.

The probable malarial origin of the disease (which is indicated by its prevalence in malarial districts when other diseases of such a nature are unusually frequent) entitles quinine to the leading place as the internal remedy, and in some instances its effect is so marked that the late Dr. Stephen Rogers, Dr. Leroy Satterlee, and others, have termed the use of large doses, combined with the tincture of the chloride of iron, "the abortive treatment of erysipelas." It is doubtless true that in the very beginning of an attack this treatment is often successful, and in the more advanced stages the tonic and antipyretic effects of these remedies are desirable.

But the local symptoms—the relief of the burning pain—limiting the extension of the disease, and thus preventing invasion of important organs—require prompt and constant attention. Before proceeding to recommend the local remedies which have been most useful in my hands, I will

mention the use of the old "lead and opium wash" for the purpose of condemning it as a vile smelling and appearing preparation, the use of which is in every respect disagreeable. I have never had reason to believe that it was any more efficacious than the plain cold water, while the bedding and clothing of the patient would be a little more decent moistened by the clear water. And yet nine-tenths of all cases of facial erysipelas are to-day treated by the use of lead and opium wash.

Dr. A. Jacobi read a paper before the Medical Society of the State of New York at the meeting of 1880 (*Ibid.*, Transactions), recommending the use of a solution of carbolic acid and oleic acid in the proportion of one part to eight. With a gloved hand, eight or ten drops of this mixture were rubbed into the skin *surrounding* the inflamed portion, and the inunction thoroughly done every ten or twelve minutes throughout the day. Such an application has the disadvantage of causing considerable irritation of the healthy skin in many instances, as all who have since used the oleates extensively can testify. If the disease be about the nose and upper lip, the odor of carbolic and oleic acid would be extremely disagreeable to some patients, even though successful, and I believe it should be our aim, as far as possible, to render remedies of all kinds agreeable.

A better remedy in the early stage of the disease is collodion, which was first suggested to me by Dr. Alex Hadden. It is to be kept painted upon as well as around the border of the diseased skin, thus forming an air-tight dressing combined with compression.

This mode of depriving the diseased part of its blood supply has often sufficed to check a well-defined facial erysipelas, even in patients who have frequently suffered from the disease. The applications should be repeated as often as required to preserve the adhesion of the collodion to the entire surface. When any considerable surface is affected, this plan is less satisfactory than white lead paint.

While several American surgeons have mentioned lead paint in these cases, the credit of bringing it prominently before the profession is due to Mr. Richard Barwell, of Charing Cross Hospital, who, in the *Lancet* of March 10, 1883, described what he termed "A Rapidly Successful Treatment of Erysipelas," which consisted in painting the parts thoroughly with white lead paint, dressing the wound, if there be any, by cotton wool saturated with boro-glyceride. The effect was remarkably and quickly successful; cases after operations on the arm for necrosis, and other hospital cases, being well in a few days. The pain was relieved almost at once, and only such after-application needed as to keep the coating perfect. In idiopathic erysipelas, he found it equally successful.

Since the publication of Mr. Barwell's cases, I have used no other local

application for erysipelas, and have often used no internal treatment except the purge as he recommends.

Pure white lead paint of the shops is likely to dry too slowly, and I tell the painter to add some dryer, as in ordinary painting, which in no way changes the effect of the application.

I am unable to give the composition of this dryer, as it is a patent preparation; but painters tell me it is some kind of resin dissolved in linseed oil.

The paint should be thicker than for ordinary use. It peels off readily when desquamation begins, even from the head, where I have often applied it.

The mention of cases in detail seems unnecessary, but several instances of especial interest have been noted. A man whose right ear was completely involved was relieved at once of the burning pain, and recovered without a second application. The same rapid results have been obtained in my practice when the disease involved the nose, face, and various other parts of the body.

Being hastily summoned to a patient who was attacked with facial erysipelas, I found that the disease began thirty-six hours previously, and had rapidly spread over the entire face. The temperature was 103° in the axilla, and the pain was severe. The husband was a painter and had the white lead paint and dryer in the house. It was thoroughly applied over the face, and they were requested to report the condition of the patient on the following day. They failed to do so, and months afterwards, when visiting a patient in the same family, I learned that the single application cured the disease.

Mr. Barwell reports similar rapid results in traumatic cases, and even in hospital cases.

While the application of this remedy gives the patient a somewhat striking appearance at times, when a single ear or the nose is affected, for example, yet it is a dry and cleanly dressing, very easily applied, and as successful as can be desired. It is beyond all question preferable to any means which have been in use up to the present time, and is still entitled to its designation as a rapidly successful treatment of erysipelas.

MYOMA.

BY

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SYNONYMS.—Myoma cutis, Fibromyoma, Liomyoma cutis (λεῖος, smooth), Myoma telangiectasia.

HISTORY.—In discussing this affection, we are, because of its so rare appearance, limited to the information derived from the observations of the few authorities who have had the good fortune to witness it. It is possible, however, that this poverty of the science in respect to it is due, in a great measure, to it having been confounded with other cutaneous diseases of a similar benign nature, especially molluscum fibrosum, and not to the fact that it so seldom exists.

Virchow, in 1854, was the first to employ the term *myoma*, and to describe, histologically, this disease as a cutaneous affection, under the title of *myoma telangiectodes*.¹ Nine years later, 1863, he says of myoma of the skin: "The external tegument presents hyperplasia of muscular fibres in different varieties of tumors: such are the deep verruca, soft verruca, deep nævi (*Virchow's Archiv*, t. vi., p. 552). In these growths, as in lepra (t. 11, p. 517), we often find a considerable hypertrophy of the muscular elements of the skin. However, this hypertrophy exists here, by its nature alone, only as a predominant element of an absolutely different production, and this muscular hypertrophy assumes the form of true tumors only in such places where the cutaneous muscular tissue has normally undergone a high state of development."²

Förster (1858), in describing tumors peculiar to the skin, remarks: "Not only fibroid tumors of the skin may be met with, but also myoma, or, in other words, fibroid tumors containing smooth muscular fibres."³

Verneuil, during the same year, on presenting a specimen to the *Société Anatomique*, stated that it was very difficult to designate this disease, since the term *molluscum*, which had been shown to belong to several different conditions, was not applicable to his case.⁴

In 1863, Förster declared that "molluscoid tumors of the skin, consisting of muscular fibres, were rare."⁵

¹ Virchow: "Ueber Cavernöse Geschwülste u. Telangiectasien." *Archiv für Path. Anat. u. Phys.*, pp. 553, 554, Bd. vi., 1854.

² Besnier, *Annales de Dermatologie et de Syphiligraphie*, 2d.

³ Förster: "Ueber die weichen Warzen u. molluskenartigen Geschwülste der Haut." *Wiener Med. Wochenschrift*, No. 9, 1858.

⁴ *Bull. de la Société Anat.*, 2me Série, xxxiii. Année, Août, 1858, p. 373.

⁵ *Annales de Derm. et Syph.*, 2me Série, tome i., 1880, p. 37.

Besnier, in 1880, contributed the most elaborate and valuable information which we possess upon the subject of dermatomyoma. He says: "Among tumors of the skin, there exist those which are essentially, or principally, constituted by a neoplasia of smooth fibres (muscular histioid tumors). . . . They belong to the class of myoma composed of smooth fibres, levicellular myoma (Virchow), leiomyoma (λείος, smooth, etc.), (Zenker), liomyoma, according to the present nomenclature."

"Our knowledge of cutaneous liomyoma, or dermatomyoma, as such, is too meagre to allow of an absolute or relative decision as to their frequency; they have been, and are to-day, confounded with different other tumors of the skin, and especially with fibroma (molluscum) and various other benign tumors; but it is nevertheless possible to say very approximately that their frequency is comparable, or slightly inferior, to that of genuine soft fibroma."¹

DESCRIPTION.—Myoma is a local affection common to both sexes, benign in character; of progressive, but slow growth; appearing in the form of maculæ, or pedicled and sessile tumors of single growth, or disseminated over the tegument, or in groups. They vary in color from a bluish-white, as in Virchow's case, to a pink or deep red; in size, ranging from that of a pin's head to that of the fist or an orange; apparently they are confined to adult and old age, occasioning the patient no alarm, excepting where the tumors have acquired a considerable size; upon removal, there is very little hemorrhage; they may possess, after extirpation, when subjected to excitation, slow and vermicular contractions, similar to those of the scrotum (Challand).²

VARIETIES.—This disease has been divided into two varieties: a simple or true myoma, and a second, which Besnier designates as *myoma dartoïque*.

In the first, the lesion appears upon the trunk and upper extremities, as in Besnier's case. In this patient, a woman, 60 years old, the eruption consisted of lentil-sized, round or irregularly ovoid-shaped maculæ, of very slight pink color, projecting very slightly above the cutaneous surface, "absolutely analogous to the eruption in the papular form of urticaria," presenting also a remarkable analogy to the elements of first appearance of dermato-lymphadenoma (mycosis fungoïde). In addition to these existed little pisiform tumors, simulating the size and form of small shot or pea, rose-colored; the large ones of a dark-red hue; they offered a smooth surface.

In the second and more common variety, the tumors appear singly

¹ Annales de Derm. et Syph., 2me Série, tome i., 1880, p. 44.

² Bull. de la Soc. Anat., Juillet, 1871; 5e Série, tome vi., 46 Année, pp. 145-149.

or multiple, limited to localized regions. This form is clearly exemplified by Virchow's, Förster's, and Challand's cases. In Virchow's patient, a man 32 years old, a small tumor was situated in the neighborhood of the nipple, having made its début thirteen years before. Its march had been slow, and it was succeeded by others of a similar character in the same region; of a similarly slow growth, their number continually augmenting. When seen at the clinic, a dozen of these growths were disseminated over an area of the thorax equal to that of a hand's breadth; most of them were situated beyond the nipple; the largest ones were the size of a cherry; they presented a smooth surface, almost glossy, and were red; the smallest, bluish-white.

In Förster's case, the affection was confined to a clearly defined tumor, suspended by a thin pedicle several lines in length to the scrotum, measuring one and one-half inches in diameter, and covered with a smooth skin.

In the two cases of M. Th. Challand, the lesion appeared in the first, a lady, æt. 25 yrs., upon the superior and external surface of the left labium majus. It had existed for two years, and while at first it remained stationary, it later grew rapidly. Upon removal it was found ovoid in shape, very much elongated, and slightly flattened, offering to the touch the sensation of an empty scrotum. It contained a small, elongated, and hard body.

The second patient, a man 65 yrs. old, offered upon the superior portion of the external surface of the right testicle a pediculated tumor, of green-almond size, with wrinkled surface, of a color similar to that of the scrotum. When pressed between the fingers, it resembled an empty grape-skin. It had, according to the patient, existed forty years.

HISTOLOGICAL CONSIDERATIONS.—The tumors consist of fasciculi of smooth muscular fibres; vascular loops of such dense plexuses as to simulate erectile tumors; large ramifying nervous branches; sudoriparous and sebaceous glands. In Besnier's case, fat-lobules were discovered in the deepest portions of the tumor. In referring to these and the situation of the sudoriparous glands upon the lateral and most profound portions of the growth, he says: "The situation of the lobules and the sudoriparous glomerules, with respect to the muscular tumor, clearly demonstrates that the smooth fibres are developed in the derm, invading principally the median and deep strata."

COURSE.—The course of myoma of the skin is exceedingly slow, as indicated in Virchow's patient, where the tumor acquired the size of a cherry in *thirteen* years, and in that of Challand, where, after a growth of *forty* years, it was no larger than a green almond.

SYMPTOMS.—These are entirely of an objective and negative character, since the disease produces no perceptible disturbance to the general econ-

omy. There is no pruritus; no sensibility upon pressure, excepting when exerted upon the larger growths. Pain, it may be said, never appears spontaneously, since the only case in which it has been present was that of Virchow, where it was so severe as to simulate the "*tubercula dolorosa*."

ETIOLOGY.—The existence of this affection is dependent upon no known cause, since it appears entirely independent of any internal or external morbid condition.

DIAGNOSIS.—This is negative. While it is possible to confound dermatomyoma with other benign cutaneous diseases, a histological examination of the product will reveal its true nature. This is especially the case when there is question of *molluscum fibrosum*, for which our affection is most liable to be mistaken. The pain developed by pressure upon some of the growths may give origin to the supposition that we have to do with *neuroma*. But these latter are *subcutaneous*, while in the cases cited we find this present in none excepting that of Verneuil, in which case some *few* only were sub-dermic.

PROGNOSIS.—As the affection has apparently no deleterious effect upon the system, the prognosis may be predicated as favorable.

TREATMENT.—This is confined to the cutaneous surface. In cases where the growth consists of isolated tumors, it proves susceptible of cure by enucleation, or removal by means of the *écraseur* or ligature. In Virchow's case, the application of muriatic ether was followed by good results.

Correspondence.

Dr. Henry G. Piffard.

DEAR SIR:—Your favor of June 18th to hands in due course. I beg to apologize that stress of business has detained me from replying to the same before. To my regret, I am unable to give you any information on the subject therein referred to, beyond stating that I manufacture chrysophanic acid from Goa powder, and that it answers in every way the tests given in the German Pharmacopœia, second edition, which will be known to you. In short, I am making the article since its first appearance exactly in every way on the same principle, and analysis of each parcel that left my factory has shown the preparation to be at all times the same. Consequently, if the character of the malady to be treated has not altered, or if the malady is not another altogether, I am at a loss to account for the deterioration alluded to.

I am, dear sir, yours truly,

E. MERCK.

DARMSTADT, August 1st, 1885.

[The foregoing is in reply to letter inclosing copy of the Editorial that appeared in the July number of this JOURNAL.—EDS.]

Editors Journal Cutaneous and Venereal Diseases, New York :

Observing with much interest your recent editorial on the apparent deterioration of chrysophanic acid, or chrysarobin, and your invitation to the profession who use this drug in their practice to communicate their experience, with a view to ascertaining whether this has been observed elsewhere than in New York, I write to add my testimony.

When chrysophanic acid was first introduced into dermatological practice as a parasiticide, the success attending its use gave rise to almost as much enthusiasm amongst dermatologists as the discovery of cocaine did in ophthalmological circles. I used it with much satisfaction in cases which had previously resisted treatment. I found twelve to fifteen grains to the ounce of vaseline sufficiently strong to produce an active dermatitis, and to destroy at one application the *trichophyton*, or other parasite for which it was used ; and, indeed, a much weaker preparation was sufficiently strong for most cases, except on the surfaces where the skin is thickest. On one occasion, an ointment containing ten grains to the ounce, applied to the ear of an adult workingman, produced such violent inflammation (closely resembling erysipelas), with such considerable constitutional disturbance as to call for active treatment to abate it ; and it lost me the confidence of the patient and the family.

But of late years I have been so disappointed in the results from the use of the drug, finding often, where I had begun with ten grains to the ounce, that it was necessary to increase it to twenty, thirty, and even forty grains, before its application produced any erythematous effect, that I had utterly lost confidence in it, and had nearly discarded its use. I just supposed it, like all other popular remedies, had been adulterated ; and I am glad to see, therefore, a movement which is calculated to bring to light the cause of the very evident deterioration of the drug, or the substitution of inert matter or some form of adulteration, and I hope the effect will be to restore to the profession a reliable article ; for, in my hands, that which was first put on the market "filled a want long felt" in dermatological therapeutics, and it is a great privation now to have to do without it, after having learned to rely upon it in a large number of cases of skin disease.

In consultation with my colleagues, I find their experience corresponds with my own, and some consider it entirely valueless.

Very respectfully,

F. E. DANIEL.

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Selections.

BOUGIES: THEIR USE AND ABUSE.

THE use of urethral bougies and sounds dates back to the earliest days of surgery. Apparently in those days, stricture not being known, they were used only for pushing back impacted calculi and other foreign bodies which obstructed the outflow of urine. Guaynerius, who wrote in 1440, mentions the use of wax bougies for this purpose.

Ferri, in the middle of the sixteenth century, described various kinds of bougies for breaking down caruncles. But it was not till Hunter, by his writings, directed the attention of surgeons to the permanent obstructions of the urethral passage, that bougies came into general use for dilating purposes. (See Voillemier, "Dictionnaire des Sciences Médicales," vol. x.)

The varieties of bougie which are employed at the present day may be classified thus:

For Diagnostic Purposes.—1, *bougie à boule*, metal or gum-elastic; 2, the urethrometer, designed by Otis.

For Treatment.—1, steel; 2, silver; 3, pewter bougies or sounds; 4, French gum-elastic: *a*, olivaire; *b*, coudée; *c*, bicoudée; 5, English gum-elastic; 6, filiform of gum-elastic, whalebone, or catgut.

For Guide Purposes.—The pilot or guide bougie.

Besides these, we have Lallemande's *porte caustique*, a bougie or catheter for applying nitrate of silver to the deep urethra; also soluble bougies, by means of which medicaments are applied to the urethral surface in a base of gelatin, cacao butter, or wax.

Let us take the consideration of these various varieties in the order in which I have enumerated them, and first we come to the *bougie à boule*. This is made either of gum-elastic or of metal, and is used purely for purposes of diagnosis. The shaft is thin, and terminates in a bulbous head, which may be made cone, pear, olive, or acorn-shaped, the last two varieties being the ones I usually use. The metal bougies have this advantage over the gum-elastic: they are more durable, and can be used possibly with more precision. The soft instruments are, however, more comfortable to the patient.

By the aid of these instruments we are able to determine the exact situation and extent of any strictures, inequality in the mucous membrane, ulcers, or tender and inflamed areas. If we examine an average-sized healthy urethra with one of these *bougies à boule*, whose bulb measures No. 22 of the French scale, we shall find that it will probably pass, without any difficulty or much discomfort to the patient, for about six inches.

Here one usually meets with a slight resistance, but not enough to impede the passage onwards of the instrument into the bladder. Now, if the bougie be gently withdrawn, as the bulb leaves the prostatic urethra two distinct catches may be felt, about half an inch apart; the first not so marked as the second, and sometimes indeed scarcely discernible. These catches are due respectively to the posterior and anterior layers of the triangular ligament. In a healthy urethra, on further withdrawing the bougie, no other obstruction is experienced until one reaches the meatus, where another catch may occur. These three catches then indicate the narrowest parts of the normal urethra.

In examining for stricture, it is well to bear these points in mind, for I have on several occasions seen surgeons—myself included—misled, diagnosing stricture (a pathological condition) when there was none. This is, of course, a serious mistake for the patient, as he is probably subjected to a course of needless, nay, mischievous instrumentation. That this may prove harmful to the patient I firmly believe, by, to use a term of Mr. Savory's, "nursing into existence" a true organic stricture. It is easy for us to comprehend the course of events leading to such a dire event. The passage of the instrument irritating the membranous urethra causes spasm and congestion, followed by inflammation, and this leads in time to a deposition of neoplastic tissue.

In examining, with a view to stricture, my method of procedure, in con-

junction, I believe, with that of my colleagues, is as follows. It is well to be provided with several sizes of searcher, as this special kind of bougie is sometimes named, say Nos. 14, 18, 22, 26, and 30. The patient standing in front of me, with the penis well exposed, I attempt to pass No. 22 through the meatus, but, should I fail. I now take the next size bougie, namely, No. 18, and find that this passes readily for two inches, but no further. No. 14 is now taken, and passed for five and a half or six inches without any resistance. Let us suppose that at this point only a slight impediment is experienced and the instrument passes on into the bladder. On withdrawing it, a distinct catch is felt at six inches, where we found a slight resistance to the introduction. It is clear, then, that we have here an urethra strictured in three places, namely: at the meatus, at two inches from the meatus, in the antescrotal portion of the urethra, and at the junction of the bulbous with the membranous urethra; that is, at the site of the anterior layer of the triangular ligament.

It is a matter now for determination as to what method to employ for the relief, or possible cure, of this condition. If you believe in the doctrine of the American school, as enunciated by Otis, namely: that strictures are curable, you will probably measure the urethra with the urethrometer. Having found the capacity of the individual urethra before you, which, let us say, measures thirty millimeters in circumference, you will proceed to cut the two penile strictures, using probably Otis's dilating urethrotome, passing afterwards *bougie à boule* No. 30 as far as the deep stricture, to make sure that all the constricting fibres have been divided. The third stricture (of our typical case) is not now dealt with, in the hope of its being chiefly, if not entirely spasmodic, and dependent on the two anterior ones.

Should, however, you be a follower of the other school, which says "once a stricture always a stricture," then you will first try gradual interrupted dilatation; and, if this do not succeed, you may have to call to your aid continuous dilatation, or internal urethrotomy.

A point with regard to the use of the *bougie à boule* is, that it, of all kinds of bougies, is apt to set up spasm. This occurs at the spot where the urethra is surrounded by the compressor urethræ muscle. Sometimes the spasm excited is sufficient to prevent the passage of the instrument. Should this occur, take a *bougie à boule* with a tapering point, or pass a small *bougie olivaire* first. You will then, after a minute or two, succeed in passing your "searcher." This also holds good in cases of spasm where you wish to pass a catheter. Here is a case bearing on this point. Not long ago, a distinguished officer in the Army Medical Department consulted my colleague, Mr. Coulson, in reference to cystitis, for which he had sought relief in vain. It was agreed that I should daily wash out and inject his bladder. On the first occasion, a full-sized catheter passed easily into his bladder, the urethra being caught unawares; but on subsequent occasions I was obliged to pass a small *bougie olivaire* before the full-sized catheter would pass. The spasm in this case was distinctly felt by the patient.

I believe that spasm exists in many more cases than surgeons imagine, either associated with organic contraction, inflammation, or congestion, or independent of these, being then reflex in its nature.

It is a matter of common knowledge, that under chloroform, a bougie which before the administration of the narcotic could not be passed, has slipped in easily, muscular spasm being allayed. Again, it has fallen to my lot on more than one occasion to see cases of presumed organic subpubic stricture, accom-

panied by stricture of or near the meatus, vanish after the complete division of the anterior stricture. After the operation for ligature of piles, how often one meets with retention of urine due to reflex spasm! Sir Henry Thompson, speaking of this, says:

"Spasmodic stricture is an exceedingly useful excuse for the failure of instruments. It is a refuge for incompetence. When you cannot pass a catheter, and wish to desist, it is a convenient thing for the operator to say, 'there is spasm.' I do not think that you ought ever to fail in passing an instrument because there is spasm. Spasm may prevent the urine from going outwards. I do not know that it ever prevents the instrument from going in. In most cases it is failure of the hand, not spasm of the urethra."

I agree with Sir Henry that one ought not to fail in passing an instrument because there is spasm, that is, some instrument; but spasm may certainly prevent the passage of a given instrument.

Besides the *bougie à boule*, there is the urethrometer devised by Dr. Otis for purposes of diagnosis. It consists of a small straight canula, of size No. 8 F., terminating in a series of short metallic arms, hinged upon the canula and upon each other. At the distal extremity, where they unite, a fine rod running through the canula is inserted. This rod, which is worked by a screw at the handle of the instrument, when retracted, expands the arms into a bulb-like shape capable of expansion up to forty millimetres. A thin rubber stall drawn over the end of the closed instrument protects the urethra from injury, and prevents the access of the urethral secretions to the interior of the instrument. When introduced into the urethra and expanded up to a point which is recognized by the patient as filling it completely (and yet easily moving backwards and forwards), the index at the handle then shows the normal circumference of the urethra under examination. In withdrawing the instrument, contractions at any point may be exactly measured.

The advantages of this instrument are these. 1. By means of it we can measure the size of the urethra, and ascertain the locality and size of any strictures present without reference to the size of the meatus. 2. It enables the surgeon to complete the examination of several strictures by a single introduction of the instrument, and by reduction of its size, to avoid the pain which usually attends the withdrawal of the *bougie à boule*.

Its disadvantages are, 1. Often a little bleeding accompanies its use. 2. By reason of the bulb being covered by india-rubber, the sensations conveyed to the hands are somewhat masked. To obviate this, Messrs. Mayer and Meltzer are now making, at my suggestion, a urethrometer whose bulb will not be so delicate as in Otis's instrument, and one which I hope to be able to use without the stall.

I now pass on to the consideration of bougies which are useful in the treatment by dilatation, and first and foremost comes the *bougie olivaire*. This has now quite superseded the English gum elastic, and, as a rule, all metal instruments, as there can be no question that its introduction is attended with less discomfort to the patient than that of steel or silver instruments. The characteristics of a good *bougie olivaire* are as follows. It must be soft and pliable, not too bulbous at its extremity, with an easily bendable neck.

Let us suppose that we have before us a case of stricture that we wish to treat in the usual way, namely, by gradual interrupted dilatation. Having found out the number, situations, and sizes of the contractions, either by the urethrometer or *bougie à boule*, should the patient not be lying down, get him to do so; if this be his first experience of instrumentation, you may thereby save him a nasty

fall, should he faint during your manipulation, an occurrence which sometimes takes place. Warm the bougie by passing it two or three times through the hand. This will also have the effect of removing any dust which might be on it. (I take it for granted that, if the bougie have been used before, it has been well cleaned.) The cleanliness of all instruments which are introduced into the urethra is a matter of the utmost importance. Who will say that, where cystitis and urethral pyæmia follow the introduction of instruments, this may not sometimes have been due to impurities introduced on or through them?

Whilst passing the bougie through the hand as suggested, give it a slight curve. I have known this curve to make all the difference between success and failure.

As to the size of the bougie; one, two or three sizes smaller than the capacity of the smallest stricture should be selected; that is, if the patient have several. This is passed gently, and removed after a minute or two; we may then succeed in passing one larger than the estimated size of the stricture. Let us imagine that, in this case, the size of the smallest of the strictures is 14 millimetres. The first bougie passed is 12, followed by 15. In two or three days, the patient comes again, saying that he has passed urine in a larger stream. On this occasion, we commence with 13 or 14 (a size or two smaller than the bougie last introduced); 16 will now probably pass easily, and so on at each successive visit until the stricture has been dilated to the size thought requisite, usually No. 22, equal in size to 12 English, or rather more; though, in some cases of capacious urethræ, it is necessary to continue dilatation to 25 or 30. The next step is to teach the patient to pass a bougie himself, and to insist on his passing it once a week regularly. It is better, perhaps, to name a day on which this is to be done. Should the patient neglect the regular use of the bougie, recontraction will almost inevitably take place. I do not believe that any organic stricture, the same being situated outside and around the mucous membrane, is to be cured in this way. If it be capable of cure, it can only be by complete division of the neoplastic tissue, which is to be effected by urethrotomy.

All cases must not be expected to go as smoothly as this. The urethra may become inflamed and irritable; if so, other means must be employed to calm the urethra before again having recourse to the bougie. A patient's food and drink, as also the weather, may make a difference in what is known as the temper of a stricture. In the majority of cases of stricture of large calibre, with care and trouble, one succeeds in so dilating a stricture that a patient will get on very comfortably, passing a bougie for himself at stated intervals.

There remain, however, a good many cases where the dilating process is not attended with success, owing to the resiliency or what not of the stricture; for such cases an operation is necessary. Of the metal bougies or sounds used for dilating purposes, I prefer a pewter one. It is heavy enough to pass in of its own weight. Its point is made on the type of the *bougie olivaire*, being sufficiently bulbous to prevent the catching of the end in the lacuna magna—which, by the by, ought easily to be avoided, whatever instrument is used, if only you recollect its whereabouts—or any other of the urethral-follicles. Its diameter is greater about the curve; the shaft, being smaller, is not so liable to be held by a small meatus; and, lastly, you may give the instrument any curve or shape you may think fit.

One sometimes meets with a case where a curved metal instrument will pass after every form of flexible has failed. Regarding the method to be employed in the introduction of curved metal instruments, as to whether one should practise

the *tour de maitre*, or pass the instrument straight in, keeping the concavity always pointing towards the pubes, seems to me to be of as small importance as the standing on the right or left of the patient. A dexterous surgeon ought to be able to pass an instrument either way and from either side. Certain it is, that several times failing with the *tour de maitre* from the left, I have succeeded on trying it from the opposite side. The introduction of the finger into the rectum, or the pressing upon the perinæum with the fingers as a point of support, after the instrument has been introduced as far as the bulbo-membranous urethra, are methods to be resorted to for guiding the point of the bougie through the triangular ligament, where often a slight difficulty occurs.

As to the use of the English gum elastic catheter, I know of only one set of cases where this is useful, and this is where the third lobe of the prostate is enlarged. Pass the catheter down to the seat of obstruction, now withdraw the stylet for one inch, and the point of the instrument will be tilted upwards, thereby enabling the catheter to ride over the protruding gland. The *coudée* and *bicoudée* catheters answer this purpose very well. This is their special function, and for it they were designed.

For the treatment of strictures of small calibre, we have the filiform gum-elastic, whalebone, and catgut bougies. Each of these has its own special and peculiar attributes. For instance, the filiform are made sometimes with a corkscrew-like twist at the end; this you will find most useful, when the stricture is at all tortuous, with its orifice situated eccentrically—that is, to one side or other of the canal. The whalebone bougie is of special use, by virtue of its rigidity, for passing through dense and callous strictures. Its extremity can be bent at will, where it is necessary to direct its point to one side or other in cases of eccentric stricture. The advantages attaching to the catgut are almost all shared by the whalebone, with this one exception—namely, that if a catgut, being passed through a stricture, be left *in situ*, it will swell slightly, thereby dilating the stricture more rapidly than can be accomplished by the other varieties.

Long catgut and whalebone bougies are also used in the railroad or tunnelled catheter—an English gum-elastic catheter, open at both ends; the catgut, having been passed through the stricture into the bladder, acts as a guide for the passage of the catheter, which is pushed on over the bougie.

The filiform bougie is often used as a guide or pilot, being, in these cases, screwed on to either a catheter, urethrotome, or some dilating instrument, as Harrison's. With several varieties of the filiform bougie, one rarely comes across a case of impassable stricture; at least such has been my experience in many hundred cases of stricture. Syme used to dwell with force on the fact, in which all surgeons of much experience in urinary diseases concur, "that there are really very few strictures which are impassable, if only the surgeon be dexterous and patient." I need not point out to you that this dexterity is only to be acquired by constant practice. If Syme taught this in his day, how much more ought it to hold good in ours, seeing how much better instruments are at our disposal!

In cases where one or more false passages accompany a stricture of small calibre, and it is desired to get a bougie into the bladder, a good method of procedure is as follows.

Suppose you pass a filiform, and you feel that it has left the urethra, and entered a false passage (this may be indicated by the grating or creaking sensation conveyed to the hand), leave it there; it will block up this road at all events.

Now, pass another; should this likewise pass into a false passage, take a third; and, should there be no more false passages for it to go into, it must per force enter the orifice of the stricture.

You will find that injection of the urethra by oil is a useful adjunct when endeavoring to pass a filiform bougie through a tight stricture; and, better still, is the plan of getting the patient to pass a few drops of urine at the time of manipulation.

I must just say a few words on the treatment of stricture by continuous dilatation—that is, the leaving in of a bougie or catheter for a lengthened period. I must own that I am no friend to this method of treatment, believing it to be more fraught with danger to the patient than internal urethrotomy. Neither do I hold with the practice of tying in a catheter after the operation of internal urethrotomy. The irritating presence of an instrument in the urethra will almost certainly set up an inflammation of both the urethra and bladder; and we may congratulate ourselves if our patient escaped with nothing worse, in the way of urethral fever, leading to suppression of urine and death. Perineal abscess, extravasation of urine, and orchitis, are other local complications. Any or all of these may succeed the mere passage of a bougie; but they are certainly more likely to occur in the treatment of stricture by continuous dilatation.

In conclusion, I will formulate a few rules which may be of service in using a bougie or catheter; firstly, as to what ought to be avoided.

1. Avoid being misled as to the presence of stricture by the deep perineal fascia.

2. Avoid the use of force in introducing an instrument. You will do more harm than good. *Apropos* of this, I will quote you a passage from Mitchell Banks, on diseases of the genito-urinary organs. "The one rock ahead is the desire which the hospital-surgeon (who must operate *coram publico*) has, even in the present day, to get into the bladder at all costs. The unhappy patient being brought into the theatre before a crowd of students, the surgeon considers it a point of honor to get something—if only a No. 1—into the bladder. After twenty minutes' prodding, with all sorts of instruments, this No. 1 is finally jammed in; the surgeon triumphs, and the patient is led away, bleeding profusely and possibly with a false passage. A week's rest in bed with hot fomentations to the perinæum, would probably so have softened down this patient's stricture that No. 3 or 4 would have gone in quite easily, to the great facilitating of further treatment.

3. Avoid hemorrhage if possible. Mr. Savory, in the *St. Bartholomew's Hospital Reports*, "On Spasmodic Stricture of the Urethra," says: "Whenever blood follows the introduction of an instrument, is it not a sign that, in one respect at least, mischievous force has been employed?" To this I would reply "Not always," as it is sometimes a necessary part of the cure, as when a patient is suffering from an obstructed urethra, due to a valve, wart, or bridle, the breaking down of which must necessarily be accompanied by a few drops of blood. It is in these cases that cure follows on the use of the bougie alone. I recollect the case of a graduate of Oxford, who came to see me in reference to his stream of urine, which was diminishing in volume, and escaped forked. He had, in addition, pain in the bulbo-membranous urethra, on the passage of an instrument, and slight gleet. After passing a No. 22 *bougie olivaire*, on two occasions, my patient was cured. On each occasion, the passage of the instrument was followed by a drop or two of blood. I imagine that in this case some wart or bridle was broken down.

4. Avoid continuous dilatation—if interrupted is inapplicable to the case, practise, in preference, urethrotomy. Cystitis is caused by continuous dilatation, but cured by internal urethrotomy.

5. Avoid tying in a catheter after internal urethrotomy; pass a bougie on the second or third day.

6. Avoid instrumentation in purely spasmodic strictures.

7. Do not imagine that, because in a given case a so-called full-sized bougie, No. 22 or 25, passes easily through the penile urethra, there can be no stricture sufficient to set up a spasmodic stricture in the deep urethra, or to keep up a gleet.

I would now offer the following advice :

1. Use great care in the introduction of all instruments; see they are smooth, clean, in good condition, and well lubricated, and if of metal, warmed.

2. Always use soft elastic bougies, if possible, and see that the *bougie olivaire* has a pliant neck.

3. More benefit is derived from a bougie which passes easily through a stricture than from a larger one, which is tightly held, and requires force to send it through.

4. It is well, before passing a bougie, to give it a curve, the concavity of which, on introducing it, should look towards the pubes.

5. When using a pilot bougie, always see that the screw is firmly fixed. After the bougie has been used several times, it is apt to become rotten at its junction with the screw. Should this be the case, on withdrawing the instrument through the stricture, the pilot might be left behind in the bladder, necessitating further prolonged operative measures for its removal. I once met with an accident of this kind, the pilot remaining behind in the bladder. I saw the patient two days afterwards, and, after performing internal urethrotomy for a stricture, was able to extract the bougie by means of a lithotrite.—F. SWINFORD EDWARDS, *Brit. Med. Journal*, July 12, 1885.

ON THE CONDITIONS WHICH PRECEDE KELOID, AND ON SOME RARE FORMS OF THAT DISEASE.

It is now, I think, generally admitted that the term keloid should be used exclusively for the disease described by Alibert, and since known as “keloid of scars,” “cicatricial keloid,” and even “false keloid.” That which is known as the keloid of Addison, and even as “true keloid,” has now yielded its claim to the name, and is known as morphœa or scleroderma. Thus an important simplification in nomenclature has been secured. I shall accordingly, in the following paper, use the term keloid only, and shall always mean the well-known disease which takes the form of raised glossy scar-like growths flat in the surface and with abrupt irregular margins, from which spurs project into the healthy skin. The commonest place for this disease is in the middle of the chest. Here it assumes its most characteristic type; here it was that Alibert first noticed it, and his beautiful plate shows a patch in this position. The terms “cicatricial keloid” and “keloid of scars” sufficiently denote the general agreement of observers that these patches are generally formed in scar-tissue. So all but universally do we find proof that a scar preceded the keloid; there have been those, and I may confess myself one of them, who have contended that it is always a disease of scar, and never begins in uninjured skin. Those, however, who hold this doctrine the most strongly, are of course very willing to admit that keloid once begun is quite capable of extending far beyond the limits of the orig-

inal scar. They are also obliged to allow that the scar which serves as the mother-tissue may have been very small, such, for instance, as the scar left by a boil. Without this admission, we should encounter a great number of cases in which keloid begins independently of scars. Nor perhaps are the characters of keloid exactly the same, when it begins in a large conspicuous scar, and when it originates in a small and almost hypothetical one. In a very large majority of cases keloid shows a tendency after some years' duration to spontaneous disappearance. The more definitely has the keloid process restricted itself to scar tissue, the more certain it is that spontaneous cure will take place. The common cases in which in children the scars of burns are attacked almost invariably get well, and their duration in many cases is only short. On the contrary, when keloid has begun in a very small scar, and has spread widely at the expense of sound skin, it persists much longer without change, and may possibly last out the patient's life. We know well what the earliest conditions are in the keloid that begins in scars. We have plenty of opportunities of observing in the scars of burns or those of syphilitic rupia that they begin to thicken, and become indurated almost as soon as the wound is healed. Respecting the stages of the cases which begin in very small scars, or as the patient may perhaps assure us, without any, we know much less, for they never come under our observation until the keloid condition is well developed. The case which I am about to relate has important and instructive bearings upon several of the questions to which I have referred. It shows us also the disease in its multiple, and therefore definitely constitutional form; and lastly, it illustrates an event which I never before witnessed, the inflammation and suppuration of the keloid growth itself.

My patient, Mrs. S., was first under my observation about ten years ago, when she consulted me on account of a keloid growth in the middle of her chest which had been present ten years. I told her that she might hope that it would gradually soften, and finally disappear, and advised that it should not be excised. She married, went abroad as a missionary, and I saw nothing more of her until recently. In October, 1884, she returned to England, and came to show me her patch. My prediction that it would soften had been in part fulfilled, but not without grave drawbacks. The upper part of the patch had become quite supple, and almost level with the skin, but at its ends and lower border the disease had spread much, and its borders were very thick and hard. The patch was now four inches long and an inch and a half wide. It ran right across the chest, and was one of the most splendid examples of keloid which I have ever seen. Mrs. S. complained that it itched intolerably, and was often very painful. During the last month it had inflamed in the middle, and an abscess had formed and broken. The formation of this abscess was attended by pain and throbbing, which kept her awake all night. She thought it possible that she had caused it to inflame by scratching and rubbing it. The history of the beginning of this patch was that there had never been any recognized scar. A hardish pimple or sort of blind boil had first been observed. This began to be painful and to itch, and gradually transformed itself into the keloid patch as we see it now. As already stated, it has taken twenty years in reaching its present size, and it is still aggressive at the greater part of its border.

Mrs. S. told me that, in addition to this, the original patch, she had several others, and two which were only just beginning. I examined these with much curiosity. On the right shoulder was a streak of induration two or three inches long, of a bright-red color, and consisting of a series of hard knots imbedded in

the skin. It had been present, I was told, several years, but it had not even yet assumed the characteristic features of common keloid. By this I mean that it had not risen much above the level of the skin, and had not gained its spurs; it was, however, very hard. Just above the navel was another long streak of similar character, but less pronounced. It looked like a scratch from a pin which had inflamed. It had been present a year, and was very hard, but not in the least glossy. The spots which Mrs. S. said were exactly like what the original of the primary patch was in the very beginning, were two small hard papules near to the streak last mentioned, on the abdomen. The papules were conical, about as large as the end of the little finger, and of a dusky-red color. They were not glossy or smooth, but looked much like abortive boils. They had been present, however, nearly a year, so that I have no doubt that Mrs. S. was right when she asserted, from the peculiar itching and pain which attended them, that they were about to become keloid. Near to them was another pustule quite as large, and to the eye one much like them, but this she said was only a little boil which was disappearing, had been present only a fortnight, and had never had any of the peculiar pain of keloid.

It should be added that Mrs. S. had on one thigh the scar of a boil, from which she had suffered some years ago. This scar had never taken on keloid growth. She had no other scars about her. There was no history of cancer in her family, but a cousin had had a cystic tumor in her breast.

We may take the conditions present in this case as examples of the mode in which keloid originates without the intervention of visible scar tissue. Looked at from this point of view, I do not think that we can claim that we can prove that keloid can originate in undamaged skin. From the form of the long streaks, I should feel almost certain that they had really been caused by scratches, and we must note that the condition assumed first is one of chronic inflammation with hardness—not of typical keloid. So also of the two chronic tubercles on the abdomen, they are not at present in the least like keloid, but show only chronic and persisting inflammation. They are like boils which refuse to disappear. Probably by a stage of long persisting inflammation, the tissue is being prepared for the true keloid growth. Good instances in proof that it is rather inflammatory damage than scar, which is the necessary preliminary of keloid, are afforded by the cases in which the lobule of the ear takes on keloid as a consequence of the introduction of ear-rings. It is clear that in such cases the quantity of scar tissue formed can be but very small, and that the chief influence is persisting chronic irritation, like that of a seton. Yet, under such circumstances, I have repeatedly seen the whole lobule become hard and glossy, take on, in fact, the characteristic conditions of keloid.

In an early period of my professional life, having been bitterly disappointed by the recurrence of keloid in the scars of my excisions and, having also repeatedly witnessed its complete disappearance spontaneously when left alone, I made it a rule never to operate. It may be a question, however, whether there are not a few cases which may suitably be allowed to form exception to this rule of practice. That it is a sound one in the great majority of cases I have not the slightest doubt. When, however, we see keloid beginning under exceptional conditions, that is, without any obvious preceding scar, and when it persists for very long periods, and is a cause of great suffering, then I think it may be fair to give the patient the chance afforded by an excision. At any rate, we may admit that our experience is not yet sufficient to make us positive in forbidding it. It may be

that even if the disease should return in the excision-scar, it would be attended by less inconvenience and pain than the original one, and that at any rate time would be gained. It must be admitted with such facts before us as that which I have recorded, that although in most cases spontaneous cure takes place, there are others which are practically permanent. I have not myself, however, for twenty years or more ever excised a really typical example of common keloid. I have operated, however, in two cases which were probably allied to it. They were examples of what has been called subcutaneous keloid, the growth taking place in the corium or even in the subcutaneous tissue, and never tending to cause the raised bossy patch which characterizes the common form. This subcutaneous, or at any rate not cuticular form, is very rare, and its diagnosis from sarcoma of the skin is very difficult. It was with much anxiety in this direction that I was induced in the two cases which I am about to mention, to advise an operation, but in both after operation the microscope showed only fibroid hypertrophy. The cases are sufficiently rare to merit individual record here.

A young woman (aged I think about 19) was transferred to my care by a colleague at the Loudon Hospital, on account of a hard mass in the skin over her left breast. There were, in fact, two indurations close together, and almost joining. The biggest was not larger than a hazelnut, but was more spread out. They were seated in the deeper parts of the skin, and projected a little above the surface, and although quite as hard as keloid, they had not assumed the smooth glossy surface and abrupt margins which characterize it. They had, however, the liability to become painful and to itch intolerably which are so often seen in keloid. On account of these conditions, and because the keloid state was not absolutely marked, I thought it best to excise the portion of skin involved. This was done, and so far as I know, no return took place in the scar. I did not, however, see the patient longer than a year after the operation. The nodules were examined after excision, and found to consist of fibrous tissue.

Another case illustrating the same condition, but on a far larger scale, occurred in the person of a sea captain who was sent to me by Sir Andrew Clark. Again the proper keloid region was the part attacked. The growth was on the front of the chest. It was to the left of the middle line, and the patch involved was three inches long and an inch and a half wide. I possess a colored portrait which well illustrates the appearances presented. They were very different from those of common keloid, for the growth was in the skin, and did not rise above its surface. The hardness was very great, but it was ill-defined, and the patch was more lumpy and thicker in some parts than in others. Where it involved the cutis, which it did in most parts, its surface was pale almost to whiteness, and although smooth not glossy. The patch had been present more than twenty years, and was increasing. It had begun as "a little spot." I excised a large elliptical portion of skin, and it was carefully examined afterwards by several trained microscopists. The conditions were exactly those of the preceding case: dense fibroid thickening of corium.

In this case there had never been any itching or pain, and there was no history of cancer in the family. Captain F. was aged 46, and in excellent health. My notes state that the plate of induration consisted "of a number of flattish lumps welded together," and add that "there were distinct seamy scars crossing it." These features are well shown in the portrait. I have heard from this gentleman recently, and he remains without any indication of recurrence. It is three years since the operation.

Having regard to the very prolonged duration of this growth (23 years), the part in which it began, and its microscopic structure, I think there can be little hesitation in classing it as keloid. Its peculiarity consisted in that it had grown downwards and laterally instead of upwards. Nor, I think, can there be much doubt that the case preceding it was an example of the same disease in an earlier stage. In neither case was there any history of scar, but in both it may be assumed as highly probable that some small scar as of a boil or of acne, preceded the keloid changes.

From what I have already said it will be obvious that I do not believe in the possibility of making a distinction between keloid of scars and true keloid, or rather that I do not believe in any true keloid in the sense of its beginning quite independently of injury to the skin. The reader who is interested in this question will find the facts stated in much detail in Kaposi's able article in *Hebra on Diseases of the Skin*.¹ There is not the slightest doubt that keloid may begin in very small scars, such as those of acne, small-pox, leech bites, and boils. It may even follow a blister if its action has been severe. In these cases the growth once begun does not confine itself to the scar itself, but often advances widely into the adjacent skin. In the exceptional cases in which there is no history of scar, it is impossible with such facts in mind not to suspect that a small one may have been present. We must alter our expression a little, and instead of saying that keloid never begins excepting in scar, say that it never begins excepting in wounded tissue. The mode of recurrence of keloid after excision is of much interest in relation to this subject. It does not recur as cancer does because the adjacent structures have been already infected, but it comes simply in the scars of the wounds made by the surgeon. Its recurrence proves the proneness of the patient to the development of keloid in all scar tissue. Such a patient would be liable to have keloid wherever he was wounded, and quite independently of the primary growth. A case in which I operated many years ago will illustrate this. After excising a round patch of keloid from the shoulder of a girl, I transplanted a flap of skin in such a manner as to prevent all tension. Soon after healing was complete, however, keloid buttons formed in nearly all the little scars left by the sutures.

Although it must, I think, be held that no abrupt line is to be drawn between the cases in which keloid begins in a large conspicuous scar obviously affecting the scar tissue, and those in which it begins in or perhaps around a very small scar, yet it might be convenient for clinical purposes to class the cases separately as varieties. It is probable that the clinical cause of the two differs somewhat. I would even ask that our conception of the keloid process may be yet farther widened. As a rule all keloid patches are peculiar by the absence of tendency to papillary overgrowth. In some cases, however, if I am not mistaken, papillary overgrowth may be followed by keloid induration in the corium beneath. I have seen several cases in which patches which were at first undoubtedly papillary, and which were attended by intense irritation, ended in induration, which was not distinguishable from that of keloid. It was only a few of the patches which were so affected. The case of a lady whom I saw many years ago with Dr. Mennell Williams, at York, well illustrated this. The patches occurred chiefly on the arms, and some of them had become almost smooth and very hard. Cases of multiple keloid are perhaps not very rare. In the instance of a negro who had enormous plates of keloid on his shoulders in consequence of a scald, and whose case I published ten or twelve years ago in the "London Hospital Reports," there

¹ See New Sydenham Society's "Translation," Vol. iv.

were numerous other smaller patches. In particular I remember that the scars left on his loins, where he had been cupped, many of them formed little keloid masses. Thus it was clear that the constitutional tendency was strong. In the same paper I recorded the details of a case in which the scar of a scald and also innumerable small-pox scars were attacked by keloid. The following are the particulars of this remarkable case, the first of its kind, I believe, on record. The patient was sent to me by Dr. Reygate, of Commercial Road :—

Mrs. O., aged 27, of dark complexion, marked with small-pox rather freely. The first spot of the keloid showed itself "like a little pimple" on the left shoulder; soon after this, another formed on the corresponding part of the right shoulder. This was about twelve years ago, and she was then in good health, but had spat blood in small quantities. Three years later she married, and she has now borne five children. Lately her chest symptoms have increased, and more of the keloid tubercles have also formed. She now has patches as large as crown pieces on the supra-spinous regions; others of varied shapes over the deltoids, a single one on the front of chest, and numerous small ones on the sides of the trunk. They all present the same features—that of raised, glossy, indurated scars. They are very painful, especially at change of weather. The pain begins with itching, and becomes in a little time of a pricking, stabbing character. If she scratches them they prick and burn much more. Sometimes they are not at all painful. On her shoulder near to a patch is seen a thin white scar; this, she says, was left by a scald; she was splashed with boiling water at the age of ten. She thinks that some of the keloid patches formed where she had been scalded; but she is sure that they did not break out until some years after the scald. She is also quite certain that many have now formed on parts where she was never scalded.

There is no history of cancer in her family. The small-pox occurred in childhood. Is it not probable that the multiple manifestation of the disease is, in this case, due to the fact that cicatrices exist in the skin of all parts from small-pox? First, we have it attacking the scars of the scald, which, no doubt, occurred on parts previously scarred by variola; and, secondly, it attacks the variolous scars themselves. Keloid appears to me to be essentially a disease of cicatrix tissue, and I much suspect that it never originates in normal skin. In this instance it was only after the discovery of a small scar that I got the history of the burn; her statement and belief was that the keloid patches had come of themselves.¹

It is an interesting question as to whether there is any relationship of keloid to cancer. We have seen in the case first mentioned that keloid tissue may inflame and suppurate, and I have several times seen it ulcerate. I have no knowledge, however, of any case in which it took on malignant conditions, and caused gland disease; nor was any such mentioned in the report of the Pathological Society's Committee, to which I have referred. In not a few cases of keloid I have obtained the history of cancer having occurred in the patient's near relatives, and in more than one I have seen keloid of a scar coincident with cancer of another part. In the case of a lady who was sent to me by Mr. Moon, of Norwood, a keloid ridge had formed in the scar left after the excision of cancer of breast. The abrupt limitation of the condition to the scar and

¹ A still more remarkable example of keloid in the scars of small-pox with a colored portrait was brought before the Pathological Society in 1881 by Dr. Goodhart, and is published in the "Transactions." With this case is given a valuable report on the disease by a committee appointed by the Society, of which Dr. Dyce Duckworth, Dr. Pye-Smith, Dr. Goodhart, and myself were members. I am entitled to praise this report because I had very little to do with its preparation.

its special conditions justified me, I think, in regarding this ridge as keloid and not cancer; I quite admit that it is sometimes very difficult to distinguish between the two. Mr. Moon told me that after the wound had healed there was for some time not the slightest hardness of the scar. It was only four months after the operation when I saw the patient. Theoretically, we may quite admit that keloid belongs to the class of new growths which have alliance with cancer, and we may expect that in a few instances such relationship will be proved by the subsequent progress of the case. I may repeat, however, that I have never witnessed such a course of events.

My paper has extended to much greater length than I had intended. It may be for the reader's convenience that I should now briefly state my principal conclusions. They are these—

(1) That with keloid, as with other skin diseases, we must not expect too close a conformity to the type form.

(2) That for clinical convenience we may recognize several varieties of keloid, the prognosis as to spontaneous disappearance and proneness to return after excision differing much in each.

(3) That the first and most typical form is that in which keloid begins in very small, perhaps forgotten scars, and slowly spreads far beyond their limits into sound skin. In most cases the extension and duration are indefinite; and the hardness, glossiness, abruptness of outline, etc., are always well marked. The proneness to recur very quickly after excision is very great in these.

(4) That in the second group, in which keloid growth begins in the middle of large scars, such as those of burns, it is seldom so well characterized. It often does not extend beyond the scar, and often, especially in young persons, soon begins to soften again and to gradually disappear.

(5) That in a third form the keloid growth is deeper, and never produces the glossy, superficial, elevated, and spurred patches which occur in the others. These cases are very slow, and show but little tendency to spontaneous disappearance. They do not develop in connection with large scars, but rather with inflammatory damage to the skin. They are less prone than the others to recur after excision.

(6) That although definite scars almost invariably precede the formation of keloid, yet that there are allied conditions which result rather from inflammation after injury than from anything which is demonstrable as cicatrix.

(7) That the cases of multiple keloid prove either that there is in some persons a remarkable tendency to the disease, or that primary patches have the power of infecting the blood and producing others.

(8) That there is little or no clinical proof of tendency on the part of keloid to pass into cancer.—DR. J. HUTCHINSON, *Med. Times*, May 23, 1885.

XERODERMA AND ICHTHYOSIS.

THESE two diseases, xeroderma and ichthyosis, are but different forms of the same malady; the main features in each are manifested by an increased formation and accumulation of epithelial scales, mixed up with more or less fatty matter and forming branny scales and hard, horny masses.

Xeroderma or dry skin is also called ichthyosis simplex, and this is the most common variety of this affection. Xeroderma is, for the most part, congenital, and its presence is not generally recognized by the parents before the first year or two of life, at which period of life the parents' attention is directed to it in con-

sequence of the harshness and dryness of the skin, and the difficulty they find in keeping certain parts of the skin, such as those covering the elbows and knees, in a cleanly condition. In quite young children, xeroderma only manifests itself by the characters just enumerated and by the tendency of the epidermis to come away in flakes. As life advances, the condition of the skin becomes more marked. The affection is then general, but differs in severity in different parts. In xeroderma the skin presents a peculiar, dry, harsh, ill-nourished and shrivelled appearance, instead of being smooth, elastic, and soft, like normal skin.

This condition of the skin is usually less marked on the palms of the hands and soles of the feet, and also on the inner aspects of the thighs, arms, and wrists. In these parts the condition of the skin appears to differ but little in appearance from healthy skin, except that it is a little dryer. The skin, generally speaking, appears to be ill-nourished, or it seems as if the skin had not been developed so as to keep up to the growth of the other parts. The lines and furrows on the skin are marked out more distinctly than usual, and this is due to the fact that there is less subcutaneous fat present than usual. The face is usually rough, dry, and furfuraceous, but the greater part of the rest of the surface of the limbs and trunk is mapped out into irregular polygonal areas, the limits of which are determined by the normal creases and folds, and the epidermis of these areas is brittle, dry, and hard, separating at the edges, thus giving to this disease an appearance very like that of psoriasis.

The skin looks dirty, the nails are ill-formed, whilst the surface is covered with thin cuticular scales or plates, which are free and loose at their circumference, but attached in their centre. Occasionally the creasings on the trunk are so coarse and deep, and the areas of epidermis between them so large, thick and symmetrical, that the patient's body presents a striking resemblance to that of an alligator.

The aspect of the scalliness varies somewhat; on the neck and trunk this disease presents a scaly appearance, on the head it is mostly furfuraceous, but on the face it is seen in the form of plates. When the scaly condition is well marked the variety is termed *ichthyosis squamosa* or *simplex*, but this is merely a well-marked xeroderma, or, as some authors say, there is no distinct line of demarcation between the conditions termed xeroderma and the mild form of ichthyosis; the difference is only one of degree as regards the epithelial collection. But the places in which ichthyosis is most marked are at the elbows and knees, and those other parts of the surface which have a tendency to get thickened under the influence of pressure and friction. Here the epidermis becomes very much thickened and hard, presenting a black or brown appearance due to impregnation with dirt, and divided even more manifestly than elsewhere into polygonal areas. Wilson states that in this affection many of the sebaceous glands are filled with a dry, hard substance, which often projects from their orifices. A condition of the skin is often met with in chronic wasting diseases, such as phthisis, and is sometimes developed with advancing years. Children suffering from this disease are feeble and emaciated, but this is not a universal rule. They are also often liable to impetigo and eczema.

The skin is functionally disordered in xeroderma; the perspiratory glands do not secrete properly, and hence the dryness of the skin; the sebaceous glands are also affected in their function, and thus give rise to a collection of altered sebaceous matter, and the epithelial scales are present in large plates or horny masses.

This form of disease may show itself shortly after birth, and rarely it may follow a general eczema which has altered the circulation of the skin.

In conclusion, it may be stated that xeroderma is a state of impaired nutrition or atrophy of the skin, characterized by roughness, dryness, and grayish discoloration; the skin is wrinkled and hard, the epidermis is thickened, sometimes desquamating and sometimes collected in crust-like masses. The perspiratory function is impaired; subjective symptoms are wanting.

Xeroderma is congenital and sometimes hereditary, and may vary in degree, and may be considered in its more severe forms as ichthyosis, which is generally accompanied by xeroderma. The term has also been applied by German writers to a rare form of atrophy of the skin with disturbance of pigment and nevoid changes.

Mention may be here made of xeroderma pigmentosum. This name has been applied to this disease by Kaposi. Dr. Radcliffe Crocker, of London, gives to it the name atrophoderma pigmentosum. This disease was first described by Kaposi in Hebra's "Diseases of the Skin," in 1870, and in 1883 he gave a more extended account of it. Early in 1884 Dr. Radcliffe Crocker showed three cases at one of the medical societies of London. These were the first and only cases of the kind known in England, and consisted of two sisters, aged respectively ten and twelve years, and a brother aged nine, out of a family of four. Of English dermatologists, Dr. Colcott Fox is credited as being the first to recognize and fully describe this disease. He says that the cases shown by Dr. Crocker were presented at another society in 1882 as forms of lupus, and that he then recognized the true nature of the affection. So sure was he of the true nature of the disease, that he had a water-color drawing made of the eldest child. He regarded sections of the tumors of these cases as indistinguishable from sections of rodent ulcer. The nature of the early stages of the affection was still open to discussion. Dr. Taylor, of New York, believes the disease primarily to be angioma. Kaposi, Vidal, and Néesser, all believe in an atrophy of the skin in this disease, but there is doubt as to whether this is the primary change.

This disease usually commenced in the first or second year without any apparent cause, affecting the exposed part of the face, neck, and extremities. It spread slowly to the first two or three ribs, also as far as the middle third of the upper arm. In the first stage red blotches or spots appeared, which faded, but left lentiginous pigment spots, or the freckles might be first noticed, which tended to increase in number, size, and depth of color. Presently the skin became very dry, and white atrophic spots appeared between the lentigines, which coalesced into larger areas. The skin in parts peeled off in thin flakes and later became contracted and parchment-like.

Some years after the beginning of the disease, superficial ulcerations, covered with crusts, appeared, and verrucose projections could be felt in the situation of some of the pigment spots. These terminated the second stage.

From the fourth to the sixth year, the third period began. The verrucose projections became the starting-point of fungating epitheliomata. The patient, whose general health had been previously unaffected, became marasmic and died exhausted, or, in a few cases, from the epitheliomatous growths affecting the body generally. Death usually occurred before puberty, but both onset and termination might be deferred. Of the thirty-four cases collated, the number of males and females affected were equal; but a peculiarity of the disease being, that if it affected several members of the same family, it usually limited itself to

the members of one sex only—seven boys being affected in one family, and five girls in another.

Vidal gives an excellent and exhaustive account of this rare disease, of which, up to the time of his description (1882), so far only one or two cases had been met with in Great Britain. Vidal speaks of it as follows: The skin disease which Kaposi has made us acquainted with under the name xeroderma pigmentosum, is a disease of families, a disease inborn or congenital, manifesting itself in early life most frequently in several brothers or sisters, affecting almost exclusively children of the same sex—in one family the boys, in another the girls. It develops almost always during the course of the first or second year of life, by the appearance, on those parts of the body which are exposed to light, of red macules surrounded by pigmented spots. The skin then becomes dry, tense, and thin; takes a glistening, cicatricial aspect, and becomes dotted with telangiectases. The epidermis exfoliates in branny scales, becomes rough on other parts, and in course of some years tumors of papillary and vegetating epithelioma appear in various situations. These form most commonly on one or several of the pigmented spots, by preference on the largest and most deeply colored. The epitheliomatous tumors ulcerate, invade large surfaces, and the majority of young patients succumb, between the ages of ten and twenty years, to the progressive generalization of the epithelioma or to marasmus, worn out by the excessive supuration.

The only disease which, in the early stage, resembles xeroderma pigmentosum, is urticaria pigmentosa; but here the disease appears by preference on covered parts. Duhring mentions, also, morphœa as very closely resembling it; and, indeed, thinks some of the recorded cases should be grouped with morphœa or scleroderma. Vidal gives a history of five cases, and tabulates thirty-one in all.

The etiology is still *sub judice*. The treatment, whether to arrest or cure the fatal course, had been completely futile. The disease was, *sui generis*, a primary atrophy of the skin, and if the history and all the characters of the disease were carefully considered, xeroderma pigmentosum could hardly be mistaken for any other affection.

Ichthyosis may be spoken of as a disease of the skin, which is characterized by the breaking up of the cuticle into polygonal aræ, which suggest the idea of the scales of a fish. The surface of the skin is dry, rigid, rough, and grayish in color, and the cuticle exfoliates in fragments, which in one place resemble dust, in others are composed of thin, glistening laminae like mica. The disease is sometimes congenital, and when not so usually develops early in infancy; it is often hereditary; it is incurable, persists through life, and affects the whole body generally. When the epithelial collections observed in xeroderma are exaggerated and marked, the term ichthyosis is applied to the disease. The scales in this form of the disease vary in thickness and color, and according to the aspect presented by them in these respects, varieties of ichthyosis are spoken of. As regards the varieties, we will find that the disease is most marked on the limbs, and the scales most abundant on the hands and feet, which are dry, horny, and wrinkled, and on the neck and face, where the scaling is dust-like.

The chief varieties are *ichthyosis cornea* or *hystrix*, which is the most exaggerated form of the disease. In this form, together with the papillary hypertrophy and the increased formation of epithelium, considerable sebum gets mixed up in some cases, so that large, dirty masses cake on the skin, and become more or less adherent; these masses being divided up by deep fissures, are best marked

over the knees. These masses also project in the form of spines and lumps. This form is also spoken of as the "porcupine disease."

The least expressed form of the disease is termed *ichthyosis squamosa*, which, as stated previously, is only a well-marked xeroderma. The characters of xeroderma may be well marked over large tracts of the body, and those of ichthyosis cornea localized to particular parts of the same subject. In both ichthyosis hystrix and squamosa, when of long standing, the scales assume a blackish appearance.

Another modification results from the presence of an excess of sebaceous matter, which, by its adhesion to the skin, produces prominent scales, *ichthyosis sebacea*. Where the disease goes on to the formation of spines of considerable length and thickness, it is called *ichthyosis spinosa*.

Ichthyosis nacrée and *ichthyosis nitida* are the forms in which the skin is somewhat thickened, and there is a mother-of-pearl-like polish of the smooth area within the meshes of the lines of motion. When the network of lines which bound the scaly patches are well marked, so as to attract especial attention, the term *ichthyosis reticulata* is applied. When the concretion of the sebaceous and epidermic substance assumes the figure of the scales of reptiles, the term *sauriasis* and *ichthyosis serpentina* are applicable." All kinds of fanciful resemblances have been suggested, such as the terms "serpent skin," "porcupine man," "man fish," and "fish-skin disease."

Anatomical Characters.—In ichthyosis the cuticle is more abundant than natural; the fibrous tissue of the derma is condensed and hard; the cutis of the papillæ is enlarged and elongated; the subcutaneous connective tissue is lax and devoid of fat; the skin appears to lose its elasticity. A well-marked patch of ichthyosis is made up of lamellæ formed by great numbers of flattened-out epidermic cells. These cells are arranged in a striated manner, and undergo fatty change in old cases of the disease. The cuticle formed in excess is hard and brittle, and breaks up into fragments corresponding with the area of the lines of motion and wrinkles of the skin. These fragments are pulverulent upon the inner side of the limbs, neck, and front of the trunk, angular and prominent in the region of the joints, and smooth, flat, and polyhedral on the internodal parts of the limbs. In ichthyosis cornea the epidermic processes, which are hard, horny, and dry, and are grouped together in an irregular prismatic form and project sometimes half an inch or more above the general surface. They are partly due to an overgrowth of the epidermis in patches, and are largely connected with the horny conversion of the epidermic lining of the sebaceous follicles. The follicles of the skin are filled with dry exuviae and dry sebaceous substances, which in some situations concrete on the surface, and thus increase the thickness of the epidermic crust.

The horny outgrowth first appears as a comedo-like body, which distends the orifice of the follicle and then rises above in a form not unlike a caraway seed. Soon this gets detached, the horny matter still growing upward distends the sebaceous follicle and its orifice until they form a mere shallow pit, which is surrounded by a reddened ring. As the disease advances, the pit becomes effaced, and now what was the inner aspect of the follicle becomes level with the surface of the skin or projects above it, but still continues to produce its horny growth. This tendency to horny development extends from the follicle to the epidermis immediately surrounding it. These bodies become opaque and black, due to the absorption of dirt.

The skin, as a whole, is marked with coarse wrinkles, due to the stiffness and hardness of its substance, and it moves freely on the fascia beneath, owing to the looseness of the subcutaneous tissue. There is also a defect in the oily secretion of the skin, likewise the watery secretion; the skin is devoid of that clearness, lustre, and transparency which is characteristic of healthy skin. In well-marked cases of ichthyosis, the hairs atrophy, and the sebaceous glands are more or less obliterated.

Diagnosis.—When the disease is fully developed, mistakes in the diagnosis are not likely to occur. The congenital nature of the disease, with the dry, harsh, non-perspiratory, scaly, ill-nourished state of the skin, showing the peculiar dark caking upon it, are the chief diagnostic features. Ichthyosis may sometimes be confounded with other affections, such as a simple, harsh, ill-nourished skin, and one affected with chronic universal eczema. The local forms must be distinguished from the warty growths, and also from a form of seborrhea, which closely resembles ichthyosis cornea.

Treatment.—The disease, though incurable, can be greatly relieved. In the first place, the patient must be kept clean and well fed and clothed if possible. If the patient is run down, cod-liver oil and quinine will be useful. Local remedies are the most important. Great benefit will be derived from baths—and the alkaline baths are most useful for removing the scales—but if the disease is obstinate, a strong alkali, applied several times a day, will remove the masses. The lotions may be used warm, if necessary (potash $\frac{3}{4}$ ss. to aqua $\frac{3}{4}$ viij.), and will readily soften the masses. In the horny form of the disease, a clear surface may be obtained by careful soaking of the parts with glycerin, or poulticing, or fomenting. When the hypertrophied masses have been removed by the bathing and washing, their reaccumulation must be prevented by continuing on with this method, or by oil or glycerin inunctions, or tar preparations to check the cell-growth. After the scales have been removed, an alkaline bath used twice or thrice a week containing $\frac{3}{4}$ ij. to $\frac{3}{4}$ iv. of carbonate of soda, or bran, to the usual quantity of water, should be used; after the bath the whole body should be smeared over with some oily substance. The simple form may be benefited by olive oil, neats-foot oil, glycerin and water, glycerin of starch; elder-flower ointment is very serviceable. The oleum theobromæ, or cocoa butter, is one of the best remedies when an oily substance is required.

The principal indications in the treatment are: first, to promote an improved nutrition of the body; second, to remove the epidermic masses and dirt; third, to stimulate the circulation of the skin by inunction and friction. I may add here that the Turkish bath and shampooing will aid greatly the means at our disposal for the removal of the epidermic masses. Mention may be made of ichthyosis of the tongue, which is described by some writers, while others do not recognize it. Dr. Church, of London, has recorded the case of a girl, aged fifteen years, who was affected by the disease on one side of the body, and about the tongue and palate.—KINNIER, *Arch. Ped.*, June 15, 1885.

ANTISEPTIC ATOMIZATIONS IN THE TREATMENT OF ERY-SIPELAS AND EXTENSIVE BURNS.

In a report to the congress held at Seville (April, 1883), on prolonged and continuous atomization as an antiseptic measure, M. Verneuil has shown that septic complications in the case of injuries may be advantageously opposed by this

procedure, which neutralizes at once the poison formed in the wound, and allows that which has been already absorbed and has produced symptoms, to be eliminated by the organism.

Among the affections originating in sepsis (including diffuse phlegmon, simple or gangrenous, septicæmia, pyæmia, etc.), erysipelas, being the one least amenable to other antiseptic measures, is also that to which this plan of treatment is pre-eminently adapted—the rapidity and often the wide extent of its invasion giving rise to difficulties that are successfully encountered by the spray, which enables us to follow up the complaint in all its migrations.

Nevertheless, M. Verneuil warns us that the spray is not to be implicitly relied upon as an abortive remedy in every case of erysipelas. “Although,” he says, “I regard this malady as contagious, inoculable, and probably parasitical, yet, knowing as I do, to how great an extent its inception and development are dependent on the patient’s constitutional condition, I am unable to believe that any local application whatever can cut short the septic process when once fairly under way. Yet the mode of entrance of the virus from without, and its propagation in the superficial layers of the derma, may warrant us in hoping that at least the local progress of the eruption, when seated on accessible regions of the body, may in this way be moderated; and indeed it would be presumptuous to deny *in toto* the advantages of topical medication in erysipelatous cases, seeing how often they have been extolled by surgeons of eminence.”

The process employed is described as follows: A “pulverisateur à vapeur,” which, as required by its size, may be either held in the hand or deposited on a table, is charged with a one or two-per-cent solution of phenic acid, or with a solution of chloral at the same strength—this last being especially adapted for applications to the face and buccal cavity, as well as for patients who are annoyed by the odor of the acid, or unusually susceptible to its action. M. Verneuil, however, has never known phenic acid, when thus employed, to produce any serious symptoms.

The quantity of fluid ejected is not large enough to wet the patient unnecessarily. If it is wished merely to moisten the wound and the erysipelatous region, the fountain should be placed further off, and the stream directed somewhat obliquely. It is also proper to guard against the patient’s catching cold. With this view, he should lie upon the edge of the bed, with only the affected part uncovered, the rest of the body being protected by woollen wraps and a water-proof investment, when possible. The bed clothes can be protected by hoops, as in cases of fractures. The face and eyes may be shielded by curtains or bandages when other regions are being operated on; but the carbolic vapor seems to be perfectly harmless when thrown freely from a one-per-cent solution into the nose, eyes, and mouth, while the face or scalp is undergoing treatment for erysipelas. This fact has led to the prolonged use of the spray, conjointly with that of other agents, in gonorrhœal ophthalmia. When the affected surface is extensive, the vapor is applied to larger or smaller portions of it in succession.

In this procedure, our first object is to disinfect the wound in the most thorough manner possible, by directing the spray into every one of its recesses. When this has been effected, two or three sittings of two or three hours each will be sufficient in the great majority of instances. During the intervals the wound is kept covered with compresses of muslin saturated with a two per cent phenic-acid solution, and overlaid with wadding and india-rubber silk, as in the ordinary antiseptic dressings.

Among the cases related by M. Verneuil is one of an amputation at the upper third of the leg, performed while the affected foot and ankle were laboring under a fully developed erysipelatous inflammation. The patient's constitutional condition being also highly unfavorable, the prognosis, of course, was anything but encouraging, yet under the use of the phenic-acid spray, complete recovery ensued. In all but one of thirteen other cases, the temperature was speedily reduced, and the erysipelas brought under control by the same means.

Equally good results were obtained in the treatment of *burns*, especially when severe and extensive, and when several days, or even weeks had elapsed since their infliction. The spray, in such cases, can be brought to bear against all the breaks and inequalities of the affected surface, thus hastening the detachment of the eschars, and opposing an effectual barrier to the advance of septicæmia.

Antiseptic pulverization will also render us important service when the ordinary Listerian applications are contraindicated or cannot be employed. Thus, in the practice of Prof. Ollier, of Lyons, a man thirty years old was affected, after amputation of the fore-arm, with such profuse and obstinate hemorrhage, recurring upon every disturbance of the dressings, that his life was endangered. In this emergency, the phenic-acid spray was resorted to, and was kept in operation upon the stump for three days continuously, after which it was employed at gradually lengthened intervals until the trouble ceased, and the patient made a good recovery.

Many other illustrative cases are detailed and commented upon, and the conclusions to which they have conducted him are formulated by M. Verneuil, as follows:

"The phenic-acid spray affords an excellent method for the treatment of erysipelas and extensive burns.

"It exerts a powerful antiseptic and analgesic influence. When the locality of the affected region permits, it may be associated with the permanent antiseptic bath.

"In none of the nineteen reported cases can it be said to have produced the slightest unfavorable result. The two deaths which they include were unavoidably caused by the great extent of the lesions. In every other instance, both the duration and the gravity of the complaint were evidently lessened."—*Bulletin Gén. de Thérapeutique*, Feb. 28, 1885.

A NEW ANTISYPHILITIC.

COMPARATIVE experiments with the various subcutaneous remedies recently introduced for the treatment of syphilis have resulted in demonstrating the superiority of Wolff's glycoll-Hg, considered as a curative agent. Its use, however, is attended with serious disadvantages, arising from its readiness to decompose, the necessity of employing only fresh preparations, its costliness, the severe pain caused by its application, and its occasional production of a bloody diarrhoea. I have, therefore, endeavored to discover some other of the amid-compounds of mercury, which, like the foregoing, should contain a product of the destruction of albumin, but should be cheaper and more readily prepared. The desired substitute, I have reason to think, has been found in a combination of the mercurial salt with urea, the diamid of carbonic acid.

I at first made use of it in a solution consisting of 1.0 sublimate, 100.0 water, 0.22 urea. This was ascertained to be harmless in its action on man, but as the

injections were painful in consequence of containing too small a proportion of urea, the quantity of the latter ingredient was increased to 0.5.

According to a carefully prepared table showing the relative effects of injections with different solutions, and of mercurial inunctions, the latter method is the least rapid in its operation. In this respect the $\text{HgCl}_2 + \text{U}$ solution compares favorably with any other. Its administration is also more easily managed, since it does not require to be freshly prepared on every occasion. 1.0 gm. sublimate is dissolved in 100 ccm. of hot distilled water, to which, when cool, 0.5 gm. urea is added. Such a solution, from chemically pure ingredients, has been in use at my dispensary for more than eight days, without losing its strength or showing any signs of decomposition. Not requiring, therefore, to be renewed daily, like the glycocoll-Hg, the trifling cost of its ingredients makes it a very *inexpensive* preparation.

But the chief recommendation of the $\text{HgCl}_2 + \text{U}$ is the *painlessness* of its application. On this account it is always preferred by patients to either the $\text{HgCl}_2 - \text{NaCl}$ solution or that of glycocoll-Hg, since it causes merely a slight feeling of tension, which disappears in from two to six hours.

Diarrhoea, so far, has never resulted from its operation, while that symptom has been observed in three of my dispensary cases after the use of glycocoll-Hg.

Mercury appears to be more rapidly excreted under the employment of $\text{HgCl}_2 + \text{U}$, the metal having been detected in the urine within twenty-four hours after a *single injection*.

Relapses are no more to be absolutely prevented by this remedy than by the other antisypilitics. Whether they are any less likely to occur is a question to be determined by future experience.

The frequent and early appearance of stomatitis after injections of $\text{HgCl}_2 + \text{U}$ may be regarded as an additional proof of its speedy elimination by the organism.—JOSEF SCHUTZ, *Deutsche Med. Wochenschr.*, No. 14, April 2, 1885.

URETHRITIS IN THE MALE AND CYSTIC FORMATIONS OF THE PREPUCE.

REFERRING to the exposition of M. A. Guerin, on the formations to which he has given the name of “conduits glanduleux,” and which are frequently met with outside the female urethra, although in its immediate neighborhood, Prof. Oedmasson, of Stockholm, announces that he has encountered lesions of this nature in man. He has met with ten cases. In three of these cases these ducts presented themselves upon both sides of the urethra, in the remaining seven only on one side. Ordinarily, they open in the neighborhood of the posterior commissure of the urethra, on the edge even of the lips of the orifice, sometimes more anteriorly, or a little more on the outside of this border. They are situated in the tissues of the urethra, which, when the ducts are inflamed, present sometimes a considerable infiltration. They are generally quite narrow, but they may be a centimetre or more in length. In eight cases the gonorrhœal inflammation from which the patients suffered, extended to the duct.

Besides these ducts of the urethra, these sometimes exist others in which the gonorrhœa may localize itself. There are situated between two layers of the prepuce, they open ordinarily upon its interior surface at the attachment of the frænum or immediately above, and they extend in the form of minute subcutaneous cords to the limb of the prepuce or beyond. M. Oedmasson

has observed six such cases. One of them was differentiated from the others, by the fact of the duct opening upon the limb of the prepuce in its middle horizontal line. Another also presented this difference that the duct passed between the two layers of the prepuce and terminated in the glans. The ducts had a length of one to three centimetres, and of sufficient capacity to admit the easy introduction of a moderately sized sound. In five of these cases, the author observed with the urethritis a discharge from the duct, a discharge which ordinarily came on a few days after the urethral discharge, in one case not until the fifth week after. In the sixth case, there was no urethritis, but only a discharge from the duct, which showed itself several days after a suspicious coitus. It could not be considered certain that this patient had gonorrhœa, but in an analogous case observed by Dr. Wilander, after the discovery of the gonococcus, the presence of a number of these bodies was demonstrated in the secretion of the small duct.

These ducts have the appearance of ordinary lymphatic cords, and the author considers it probable that a lymphatic vessel, engorged from some cause or another, had been occluded and had broken an issue through the skin. He gives, as proof of this hypothesis, that at the very point where these ducts are located, there are frequently found small lymphatic cysts, of the size of a pea or of a bean and of a slightly variable form which have generally existed since infancy. The author has demonstrated the presence of these cysts in seven cases, and, in two of them, there existed simultaneously glandular ducts from the urethra.

In the treatment of these different species of ducts in both sexes, the author introduces, when they are not too small, a fine sound covered with a small amount of absorbent cotton dipped in a solution of nitrate of silver, of sublimate, or of tincture of iodine.—E. OEDMASSON, *Nordist Medicinskt Arkiv*, 1885.

BELLADONNA AS A MEANS OF PRODUCING TOLERATION OF IODIDE OF POTASSIUM.

FROM observation of the fact that belladonna produces dryness of the throat, mouth, and nose, Dr. P. Aubert got the idea of employing empirically this agent, in order to combat certain disagreeable effects of iodide of potassium.

In three well-marked cases of naso-pharyngeal intolerance, the administration of belladonna with the iodide gave good results. The same success was obtained in the case of a young man suffering from acute iodism, the symptoms disappeared by preceding the ingestion of the iodide with extract of belladonna. In this case, the dose of belladonna was a pill containing 5 centigrammes given twice a day, night and morning.

In one of these cases, after the belladonna had been continued for several days, it was suspended, and the iodide was still employed without a supervention of the intolerance.—*Journal de Méd. et de Chirurgie*, May, 1885.

AT WHAT EPOCH DOES SYPHILIS BECOME CONSTITUTIONAL?

THE author begins with a critical review of modern experiments concerning the question, whether the initial sclerosis should be regarded as a purely local affection or rather as a symptom of constitutional syphilis, and demonstrates that excision of the diseased part has not as yet furnished decisive results. Even inoculation, and especially auto-inoculation, generally so sure, shows itself here sometimes deceptive, for a result apparently negative may, after some time, give

place to an eruption of the characteristic signs of syphilis. The second inoculation requires a certain period of incubation, and if this inoculation be performed before the initial sclerosis has had time to entirely poison the organism, it happens that the result of the auto-inoculation remains negative at first, but where the period of incubation is completed, it develops a new sclerosis or papules. A large number of experiments undertaken at the Copenhagen Hospital, and five of which are described in detail, prove the justice of the opinion of the author upon this point.—E. PONTOPPIDAN, *Nordist Medicinskt Arkiv*, 1885.

Review.

VORLESUNGEN ÜBER PATHOLOGIE UND THERAPIE DER SYPHILIS. Von PROF. DR. EDUARD LANG, Vorstand der Syphilitisch-Dermatologischen Klinik an der Universität Innsbruck. Wiesbaden: Verlag von J. F. Bergmann, 1884.

We are in receipt of the first two parts of this work, which the author announces will be concluded during the course of the year.

These lectures open with an extended history of the subject, embracing a period which originated with our first knowledge of syphilis, and which terminates with the present. This period has been divided into three parts. First: This begins with our information derived from the earliest Hebrew writers, as indicated in the Bible, and concludes with the epidemic at the close of the fifteenth century. Second, beginning at the year 1495, terminates with the promulgation of the results of Ricord's investigations. These researches at the Hôpital du Midi, which decided the question of gonorrhœa and syphilis as two distinct affections, and the division of this latter into primary, secondary, and tertiary forms, marks the opening of the third period, which is continued to the present day. This first part of the work contains, in addition, lectures upon the initial manifestations of the disease, which are presented in all their various phases, including syphilis vaccinata. Much more space than is usually allotted to the subject has been given to mastitis syphilitica simplex et gummosa. Nearly one-third of Part I. treats of the various species of syphilides, thus affording a complete exposition of each and every variety of this form of manifestation. The second lecture is devoted to the fever of syphilis. Syphilitic vaccination also receives a conscientious review. The part is concluded with the affections, specific, of the hair and nails.

Part II. includes the various organs of the economy as affected by the disease. These the author has discussed in detail, thus embracing the entire organic system. An important part of this volume is consecrated to specific affections of the bones, muscles, tendons, joints, etc. It closes with syphilitic affections of the central and peripheral nervous systems, and the sensory organs.

We would call special attention to the number of exceptionally well-executed woodcuts with which cases are exemplified. It is no exaggeration to say that we have never seen the different lesions so well demonstrated by this class of engraving as is found in our subject of review.

As will be seen, notwithstanding the brevity of our notice, the scope of the

work is extensive, and the author has exhausted the subject. He has treated it with a masterly hand. In diction, it is at the same time choice and comprehensive. In a word, it bears the impress of a scholarly mind, and demonstrates the fact that Prof. Lang is thoroughly versed in his subject.

We can heartily commend the work to the profession at large. But it is the specialist particularly who will appreciate it, and who will find that, although no new theories have been advanced—we refer to the parts under review—it is a very valuable addition to the literature, since the subjects are treated *in extenso*, while other writers have devoted a much more limited space to them.

We can pass no higher encomiums upon it than to express the hope that it will soon be translated into the English language.

In conclusion, we would say that we anticipate with pleasure the appearance of the remainder of the work, and feel assured that it will fulfil our expectations.

Item.

THE AMERICAN DERMATOLOGICAL ASSOCIATION held its ninth annual meeting at the Indian Harbor Hotel, Greenwich, Conn., Aug. 26, 27, and 28; Dr. W. A. Hardaway, President, in the Chair. The following-named members were in attendance: Drs. Alexander, Denslow, Duhring, Fox, Graham, Greenough, Hardaway, Heitzman, Hyde, Morison, Piffard, Robinson, Rohé, Sherwell, Stelwagon, Taylor, Tilden, White, and Wigglesworth.

The following papers were read: Address by the President, Dr. W. A. Hardaway. 1. A Case of Tuberculo-Ulcerative Syphilide of Hereditary Origin, by Dr. J. E. Graham. 2. Clinical Notes on Psoriasis, by Dr. F. B. Greenough. 3. Remarks on a Moot Point in the Etiology of Psoriasis, by Dr. S. Sherwell. 4. Relations of Lupus Vulgaris to Tuberculosis, by Dr. J. N. Hyde. 5. The Treatment of Lupus by Parasitocides, by Dr. J. C. White. 6. Cases of Angioma Pigmentosum et Atrophicum, by Dr. J. C. White. 7. Clinical Notes on Eczema and Psoriasis, by Dr. W. A. Hardaway. 8. Report of Two Unusual Cases of Dysidrosis, by Dr. G. H. Fox. 9. On the Histology of the Vegetable Parasitic Diseases—*Tinea Trichophytina*, *Tinea Favosa*, and *Tinea Versicolor*, by Dr. A. R. Robinson. 10. On the Structure of the Derma and the Development of Elastic Tissue in it, with Demonstrations, by Dr. C. Heitzman. 11. Case of Neuroma of the Skin, by Dr. W. A. Hardaway. 12. Relation of Herpes Gestationis and Certain Other Forms of Disease to Dermatitis Herpetiformis, by Dr. L. A. Duhring. 13. On "Mycosis Fongoïde," by Dr. G. H. Tilden. 14. An Unusual Case of Tylosis of the Hands, by Dr. R. B. Morison. 15. Remarks on Electrolysis and Other Practical Topics, by Dr. C. Heitzman. 16. On Syphilitic Re-infection, by Dr. R. W. Taylor. 17. Observations on the Oleates, by Dr. H. W. Stelwagon. 18. The Treatment of Acne by the Use of Sounds in the Urethra, by Dr. L. N. Denslow. 19. A Case of Syphilitic Aphasia and Paraplegia Followed by Death. With an Account of the Autopsy, by Dr. L. N. Denslow.

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EDITORIAL NOTE.

THE appearance of the chromo-lithograph, which was prepared for the October number of this JOURNAL, has been delayed from the failure of the contributor, by reason of sickness, to furnish the descriptive text.

It will appear in the November number.

A CASE OF TUBERCULO-ULCERATIVE SYPHILIDE OF HEREDITARY ORIGIN.¹

BY

J. E. GRAHAM, M.D.,
Toronto, Canada.

THE following case, which came under my observation during the winter of 1881, presents in an extensive and striking form a tuberculo-ulcerative syphilide of hereditary origin. I am indebted to Dr. Aikens, of Toronto, for the privilege of examining and noting the progress of the case.

S. J., æt. 16, born in Canada, was first seen by me in February, 1881, when these notes were taken. She enjoyed moderately good health up to the commencement of the present disease. She had never suffered from any severe illness and, so far as known, she never had any previous eruption on the skin, nor has she shown any early manifestation of syphilis. About five years ago, she received a blow from a stick on the right forearm, a short distance above the wrist. The part was not cut, but was bruised. The ecchymosis disappeared in about a week's

¹ Read at the ninth annual meeting of the American Dermatological Association.

time. In a few days after its disappearance, a local swelling commenced which in turn suppurated and discharged matter. The ulcer produced in this way never healed up, but spread very slowly, so that, at the end of the year, two or three ulcerated patches existed instead of one. At the



end of the second year, the disease had extended half-way up the forearm. At the end of the third year, the ulceration had almost reached the elbow. During the fourth it passed over the joint, and now in the fifth year it had extended along the arm nearly half-way up to the shoulder.

Throughout the whole course of the disease, a very imperfect form of



ciatricial tissue has followed the ulcerative process. The integument was not completely destroyed, as many small islands of sound skin remained. The ulceration was in most places very superficial, and in no place was it very deep.

There is no history whatever of acquired syphilis.

Present condition.—Patient is pale and somewhat anæmic, but does not present any of the ordinary features of hereditary syphilis. Her

general health is very fair, and she is moderately well nourished. The right arm presents the following appearance. From the wrist to the elbow there is very little healthy skin, its place being taken by cicatricial tissue; very little secondary ulceration has taken place in the old cicatrix.

The forearm has a hard feel, and presents, on its surface, elevations and depressions, and is covered in places by thin scales. The disease does not seem to extend deeper than the subcutaneous areolar tissue, as she is able to move her hand and grasp with the fingers. The parts over the ulnar are more atrophied than in other parts of the limb. The wrist presents some spots of ulceration, but the disease has not spread to the hand.

The hand is swollen and œdematous, owing to interference with the superficial venous circulation.

The elbow is covered by the same form of tissue as the forearm. The joint is but slightly movable, owing to hardening of the surrounding tissue.

The arm, for about three or four inches above the elbow, is atrophied and covered by the same cicatricial tissue. At the extremity of the cicatrix, there is a ring of ulceration beyond which the skin is healthy. The line of ulceration extends completely around the arm, and is about half an inch in width. It presents a peculiar worm-eaten appearance. The ulcerating process seems to begin in the epidermis, and extends into the deeper structures. This gives the skin a peculiar bevelled appearance. Immediately beyond the ulcerating line, beneath the sound skin, there is a ring of induration. The latter, however, is not very well marked. There was no appearance of nodules such as are found in lupus.

The left clavicle presented about its centre a very marked thickening, and immediately underneath this swelling an ulcer existed in the skin. The latter was about the size of a fifty-cent piece. The sore has a hard, infiltrated edge, and does not show any sign of healing. Both the enlargement and the ulceration were the result of a blow.

None of the sores presented that peculiar copper-colored appearance common in syphilis.

Heart and lungs healthy. The urine normal in character.

Family History.—Her mother is living and healthy. She has three sisters, all older than herself. They are also healthy. I was unable to get any reliable account of her father's illness and death until quite recently. He died when the patient was about eighteen months old, now about seventeen or eighteen years ago. The immediate cause of death was pneumonia, but he was suffering at the time from tertiary ulceration of the throat. On account of the somewhat sudden death, a

coroner's inquest was held, and the fact of his having had syphilis was thoroughly established.

Treatment.—Mild mercurial ointment was applied to the arm. Internally a mixture containing $\frac{1}{4}$ gr. bichloride, 5 grs. potass. iodid. to the dose, with tr. columbo was given.

Under this treatment, the patient steadily improved. The ulceration healed up both on the arm and under the clavicle, and the general health became much better.

The diagnosis in the case was a matter of difficulty. No history of syphilis could be obtained at the time, and the ulceration presented so much the appearance of serofula that I had put the case down as one of ulcerative serofuloderma. Dr. Aikin, however, determined to adopt an anti-syphilitic treatment, which, as above shown, was quite successful in curing the patient.

Taking all the facts into consideration, there can be little doubt but that we have here a tuberculo-ulcerative syphilide¹ the result of hereditary disease—a condition which did not develop until the patient was twelve years of age. So far as could be ascertained, there was no sign of the disease during infancy or childhood.

The difficulty of the diagnosis led me to inquire into the literature of the subject, when I was struck with the short description given in some text-books, and its complete omission in others.

In Bumstead and Taylor, under the head of "Tubercular Syphilide of Hereditary Origin," occurs the following: "This lesion, much rarer in hereditary than in acquired syphilis, may occur as early as the sixth month, or a second attack may be met with several years after birth." A very clear and succinct description is then given of the disease.

It concludes as follows: "Similar eruptions are also seen in serofulous children, but the greater surrounding hyperæmia, which is of a bluish rather than a coppery color, in the serofulous affection, and the points already given in the description of ulceration of acquired syphilis may aid in the diagnosis."

These authorities speak of a second attack occurring later in life, which indicates that they consider that a first attack always comes on in infancy. In this case there was no history whatever of infantile syphilis. The means of diagnosis above given would also have been quite inadequate in this case, as the ulceration in outward appearance resembled more a serofuloderma than a syphilide.

In Lancereau's work on "Syphilis," two cases are reported from Cazenave of two girls, one nine and the other eighteen, in the latter of

¹ I have used the term tuberculo-ulcerative for two or three reasons. The induration which preceded the ulceration, and the somewhat serpiginous character of the latter, made it resemble that form of syphilide more than any other.

whom the symptom appeared at ten years of age. They had tubercular and serpiginous eruption which had no serious effect. It was impossible to find any primary lesions, the existence of which was now rendered very improbable by the age at which the secondary phenomena had appeared. The first case was cured by the use of the proto-iodide of mercury.

Tilbury Fox is of opinion that many of these later lesions of syphilis are confounded with strumous inflammation. He further states: "I have seen papular, bullous, pustular eruptions, ulcerative and gummatous disease clearly traceable to inherited syphilis, in children of four, five, ten, and even in young persons of seventeen or twenty years of age." He then gives a general description of these latter eruptions, mentioning the tubercular and ulcerative among others.

In Hebra's work, a very clear description is given of the serpiginous tubercular lesion as it occurs in hereditary and acquired syphilis. He speaks of its resemblance to a condition found in Norway, to which their physicians have given the term *Radesgye*.

It would certainly be of great advantage if there existed a classified list of these later skin lesions of hereditary syphilis, together with a clear description of each, such as is given in those resulting from acquired syphilis. Such a work would render the diagnosis of these obscure cases an easier matter than it is at present.

A very important question is raised by the history of this case, viz., that of the tardy development of syphilis. Can such a lesion as has been described appear on a patient at the age of ten or twelve, or even later, who has not had infantile syphilis? This question has been raised again and again, and to judge from the work on skin diseases lately published in connection with Ziemssen's *Encyclopædia*, it is not yet settled.

I can only say for this case that I endeavored in every way to obtain information both from the patient herself and from her mother, as to the previous existence of early symptoms of syphilis, and I could get no history of any such condition.

REMARKS ON A MOOT POINT IN THE ETIOLOGY OF PSORIASIS.¹

BY

SAMUEL SHERWELL, M.D.,

Brooklyn, L. I.

AT various times, in discussions in the New York Dermatological Society having relation to the etiology, etc., of psoriasis, I have been struck by the fact that among some of the members there

¹ Read at the meeting of the American Dermatological Association, August, 1885.

has been a manifest divergence of opinion as to the *ordinary general health* of individuals suffering from this trouble; so marked, indeed, have been some of the expressions of opinion that, to fortify or correct my own convictions on the subject, I have been led, as opportunity offered, to look up the older and indeed most authors as I think of any weight in matters dermatological, to see if I could arrive at anything like a "consensus" of opinion on the subject.

My own belief and experience agree so with Hebra's, to which I need not more than allude to here, that I only prefix it in order to make any prejudices that I may have more manifest. I have tried, however, to be just in the brief abstracts and condensations given below. The French authors, in point of precedence among the continental writers, seem to have the right of line; with the writings of the fathers I shall have nothing to do, as I think we should consider it unnecessary and useless.

French.

Alibert (1825), Rayer (1835), Gibert (1840), Hardy (1860-64), Bazin (1868), are all of accord; perhaps Alibert's conclusions make the best summary. He says, "it ordinarily attacks strong, robust subjects, in whom predominate the bilious and sanguineous temperaments."

Bielt (1828-38) and Cazenave (1868) do not differ essentially from the foregoing; the former, however, insisting upon its occurrence from disturbed mental and emotional states, which it might seem reasonable to believe have a "*post hoc, ergo propter hoc*" basis.

The latter speaks of it as always occurring in those of rheumatic diathesis; neither of them have much to say directly bearing on relative *general health*.

Of course, in all the earlier authors, the ever present elating and confusion of terminology have been considered; the admixture of terms lepra and psoriasis are easily separable, and it will not be necessary to allude to it again in later parts of this paper.

German.

Fuchs (1840) is non-committal as to general health of patients, but gives a variety of supposed causes, moisture, emotional disturbances, etc., etc.

Gustav Simon (1848)—"All is empty speculation as to cause"—says nothing about average general health.

A. Weyl (Ziemissen's "Handbuch") has nothing to say about general health in a definite way; gives, however, his views of etiology, attributing the disease in question, in a somewhat obscure manner, as being due "to irritation of the nerves distributed to the skin in the tracts affected," which is probably true, but looks somewhat like begging the question.

The remainder of the German authors looked up on the subject—Neumann, Kaposi, Behrend, Lassar, etc., etc.—substantially agree with Hebra's views; Kaposi giving perhaps the most pointed delivery; *sic*: “People who have psoriasis are thoroughly sound, robust, feel perfectly well, and there is no such thing as dyscrasia or diathesis” about them.

English.

It is when we turn to the English authors that we find the most fanciful theories and attempted explanations of causation in this affection.

Daniel Turner (1736), so far as I could find, has little to say beyond the relation of his clinical cases and their treatment; judging by inference from some of his descriptions of treatment of psoriasis inveterata, some of his patients at least, one would suppose, must have had pretty robust constitutions to stand it.

Willan (1809) says little on the point in question, but in psoriatic cases believes he has found rheumatic and scrofulous conditions present.

Bateman (1814), equally non-pronounced, but has seen cases occurring in puerperal states, and others in which melancholia, chlorosis, and arthritic conditions have been present.

Jonathan Greenc (1841), non-committal, or non-observant.

Samuel Plumbc (1837) attributes psoriasis in general to mental worry and other causes bringing on general debility; mentions, however, as a fact its occurring for the most part in the upper and best nourished and conditioned classes; he contradicts himself, as to debilitated general health, in foot-note, and at the end of his chapter on the subject speaks of masturbation being a cause, and a frequent one.

Erasmus Wilson gives a list of about twenty diseases and diseased conditions as bearing on, and productive of, this skin affection (Hebra's remarks refuting his assertions are of interest in this connection).

Non-committal as to the direct point of this paper, by inference he attributes this diseased state to the most opposed diatheses—says that four per cent of a certain list of cases given were traced to consumptive stock, etc.

Hunt (1847–71) says very little about general health, but thinks there is constitutional predisposition, which on the whole we think probable.

Neligan (1852) speaks of a suspicious heredity, has a leaning to the scrofulous diathesis as being conducive; mentions its common enough occurrence in strong, healthy, plethoric young persons.

Gaskoin (1875), in a treatise on psoriasis and lepra meant to be exhaustive on this subject, gives a number of theoretic causes, some apparently ridiculous, as sepsis, asthma, etc., etc. Nothing definite as to general health of patients.

Tilbury Fox.—“It occurs,” he says, “most often in subjects between fifteen and thirty, and in those of sanguineous temperaments,” says nothing about general health, except the inference to be drawn from the foregoing.

American.

Piffard (1876) not exact on the point in question, mentions the fact of its occurrence in otherwise healthy persons, believes that the rheumic diathesis is the great predisposing cause, and that exciting causes are various, that prevention of proper oxidation of tissue is the chief.

Dulring, while giving in quotation some of the various theories of its production, commits himself to none; mentions, however, as simple fact statement, the well-known fact of its common appearance about the time of ordinary most blooming health, as in young adults.

Hyde says it appears indifferently in those of the strongest and weakest constitutions, and in combination with diatheses of the most varied character.

G. H. Fox.—“The majority of psoriatic patients seem as strong and hearty as the average of mortals.”

Bulkley.—“Very many psoriatic patients appear in perfect health, but in most a condition of faulty assimilation can be made out.”

Robinson.—“It occurs equally in chlorotic, tuberculous, and well-nourished, healthy persons.”

This, then, is the brief résumé of expressed opinions of the authors named.

I have tried to spare the Association the deluge that more copious quotation and extracts would necessarily involve.

I have tried to be just, as well as brief, but am inclined to think that the conclusions, taken as a whole, balancing weight of authorities, etc., go to strengthen my expressed convictions as to the general good health of individuals having this skin affection.

I think I may say with safety that about fifteen thousand cases of skin disease have passed under my observation, and while my attention to the point in question has been more direct and careful of late years than formerly, I have always been struck by the high general average of health, to all appearances at least, of the affected persons. I can now only recollect one case of psoriasis in which, from appearance or complaint of the individual, I was led to physical examination for phthisis.

In that case I certainly found lung trouble and evidences of a cavity, but judging from her history of the length and continuance of the symptoms themselves I was not clear then, nor am I now, as to whether it was tubercular in origin, or simply a bronchiectatic dilatation.

In my lectures, it has always been my practice to lay stress upon this point, that of general health, as important and differentially diagnostic in

itself, and when cases of the kind present themselves at my clinics, I am accustomed to dilate upon them somewhat in the following manner, in order to impress and fix what I believe to be a fact in the minds of the students:

"Here, gentlemen, you have a case of psoriasis (pointing out the eruption and its elective seats); note the general robustness of this patient; these folks never die, unless they get run over by a locomotive, or catch double pneumonia," etc. There is yet time for me to correct myself if I am wrong in so teaching, and I shall be glad if the subject is thought worthy by you to have a decision from the most competent court I am acquainted with.

Some year or two since, I did myself the honor of reading a paper before this body on psoriasis and pseudo-psoriasis of palms, etc., in which I spoke of my belief in the excessive rarity of the first, and the almost certainty of the syphilitic diathesis in the other. I have changed my opinion but little since then; there may be cases of frank palmar psoriasis, but they are very rare, in my opinion. The reason of my present allusion to it now is this, that in my remarks at that time I used as an illustrative parallel the extreme infrequency, to say the least, of the appearance of herpes zoster on the *vola manus*; since then, and showing that nothing is impossible, I have seen a case of this last in that locality (at least I could not otherwise diagnose it), my *first* and *only* one. In these cases of palmar squamous syphilides, I have been frequently struck also by the excellent types they have presented of former perfect health. That diathesis being, however, present, they might be called magnificent ruins.

As to any new points on the etiology of psoriasis, I have nothing to present, not even a new theory, and most authors I find, and as has been shown, avoid or obscure the subject. It seems to me that dermatology in that particular is under obligation to Dr. Piffard. Among the very many good things in his work of 1876, he defines his theory of causation in chapter on rheumides, etc., and gives his reasons for his faith therein, in far better, fuller, and more scientific manner than any other author to my knowledge.

His collocation, where not original, explanation of phenomena, and arrangement, seem to me excellent.

AMERICAN DERMATOLOGICAL ASSOCIATION.

NINTH ANNUAL MEETING, HELD AUGUST 26, 27, AND 28, 1885.

*Official Report of the Proceedings by the Secretary.**Wednesday, August 26—Morning Session.*

The President, DR. W. A. HARDAWAY, in opening the proceedings, said that, although he had no formal address to make, he felt that all would agree with him that great good had been accomplished in the work for which the Association was established since its preliminary organization ten years ago. It had been fertile for good in furnishing a stimulus to the study of dermatology, and had been especially valuable to those of its members who lived at a distance from the greater medical centres. Although interest in the meetings had at times seemed to flag, he felt that the Association would continue to prosper, and that its success was now assured.

He expressed the pleasure it gave him to once more look upon the faces of the older members, extended a hearty welcome to the new members, and declared the meeting open for its regular scientific work.

The first paper was read by DR. J. E. GRAHAM. It was entitled:

A CASE OF TUBERCULO-ULCERATIVE SYPHILIDE OF HEREDITARY ORIGIN.¹

DISCUSSION.

DR. TAYLOR expressed the belief that it is now generally conceded that syphilis can be communicated to the child by the father without infection of the mother (a view which he was the first to advocate in America), although it had long been rejected by many well-known authors. He thought that the case reported was undoubtedly such a one. He and his colleagues, at Charity Hospital, Blackwell's Island, had made repeated and thorough examinations of mothers who had recently given birth to syphilitic children, without finding the slightest evidence of the existence of the disease in them.

An interesting circumstance brought out by the paper was the absence of early symptoms of the disease in the girl. This is often stated in histories of such cases, but he felt confident that the assertion was not well founded, in view of the ease with which a slight coryza, roseola, or onychia might be overlooked. He believed that there must be some early manifestation of the disease in all cases. Deep ulcerative lesions may develop in such children as early as the age of six months, but they did not do so always. His experience had taught him that, while serious lesions, such as gummata, might develop during the first year of

¹ See page 289.

life, they might also remain away until the age of fourteen or eighteen years.

Another important point illustrated by the case was the effect of traumatism in furnishing a starting-point for the evolution of hereditary syphilitic lesions. He cited the case of a boy suffering from hereditary syphilis, in whom a wound of the leg by a stick had been followed by deep ulceration of specific nature. He thought the arguments advanced in the paper conclusively established the syphilitic nature of the malady. It is often impossible to accurately determine the nature of certain ulcerative processes from a limited number of examinations of the patient, a careful study of the family history and the concomitant symptoms being essential, and in many cases, the results of the internal treatment must be taken into account, in order to reach a satisfactory conclusion.

DR. GREENOUGH said that he had recently seen a striking case which went to establish the truth of the doctrine that the father could infect the child without giving the disease to the mother. It was that of a woman who had given birth to three children in succession, all of whom had died from a pemphigoid syphilitic eruption breaking out a few weeks after birth, the woman herself remaining perfectly healthy as far as he could ascertain, during several years' observation.

DR. HEITZMAN said that, in cases similar to the one reported, which were common, it is often impossible to make a diagnosis between syphilis and scrofula. He had recently seen a young man with an extensive ulceration, ten inches in diameter, in the groin. He had been unable to make a diagnosis at the first interview, and told the patient so. He had never seen him since.

DR. WHITE thought that local treatment alone often cured such lesions as those described by Dr. Graham and illustrated by the photographs shown, and he did not think it safe to base a diagnosis between syphilis and scrofuloderma upon the effect of combined treatment. Diagnosis was, in fact, often a matter of extreme difficulty in such cases, and he had had many patients whose disease he was firmly convinced was syphilis, although unable to advance any valid evidence for his belief. It seemed to him possible for the throat disease in the father of Dr. Graham's patient to have been of a scrofulous nature.

DR. GRAHAM said that the physician who had treated the throat affection had pronounced it syphilitic.

DR. DUHRING also alluded to the great difficulty of making a diagnosis in such cases as that of Dr. Graham. The result of the treatment, however, inclined him to believe the case one of syphilis. He thought the complete cure in so short a time as two months very remarkable. This fact also spoke in favor of the case being one of syphilis rather than scrofula.

DR. HYDE said that since he had written on the subject, he had seen a number of cases of children, born syphilitic, in whom most careful examination of the mothers showed no signs of the disease. These cases, however, had not taught him to go as far as Dr. Taylor, who had spoken of vigorous women bringing forth syphilitic offspring, as almost all the mothers were in delicate health.

He had never seen inherited syphilis develop for the first time in ad-

vanced life, and was unable to believe in the existence of a tardy inherited syphilis.

Alluding to the stress laid in the discussion upon the history of cases, he remarked that the more he saw of the disease, the less importance did he attach to the histories given by patients. The disease was so common that accidental cases were of frequent occurrence. One case came into his thoughts at the moment, in which he was satisfied that an ulcerative lesion on the penis was caused by inoculation from the hand of a syphilitic surgeon during the introduction of a catheter.

DR. HARDAWAY thought it a poor rule in practice to pin our faith upon the results of treatment. Such lesions as those described in the paper were often cured by local treatment alone; hence the fact that they disappeared under combined internal and external treatment was no proof of their syphilitic nature.

DR. TAYLOR said that he also did not regard treatment as "*la pierre de touche*" of diagnosis. A careful study of all three factors—family and clinical history, and the results of treatment—are all of importance.

He did not agree with Dr. Hyde, that mothers (of syphilitic children) in whom no positive evidence of the disease could be found, were generally in delicate health, since he had repeatedly seen robust buxom women bring forth such children. They might wither and become pallid afterwards, of course, but not necessarily from syphilis.

DR. GRAHAM said that it had been found impossible to make a diagnosis in his case until after treatment.

DR. GREENOUGH then read a paper entitled

CLINICAL NOTES ON PSORIASIS.

It was based on the observation of 394 cases of the disease, which occurred in a number of about 15,000 of general skin disease, or in the proportion of a little over $2\frac{1}{2}$ per cent. 205 cases were in male subjects, and 188 in female.

The ages of the cases when first seen were:

Under 10 years,	. . .	21	From 40 to 50, . . .	42
From 10 to 15,	. . .	33	Over 50, . . .	50
" 15 to 20,	. . .	47		—
" 20 to 30,	. . .	129		394
" 30 to 40,	. . .	72		

In 44 cases the patients were seen during the first attack of the disease. Their ages were:

Under 10 years,	. . .	7	From 30 to 40, . . .	6
From 10 to 15,	. . .	5	" 40 to 50, . . .	5
" 15 to 20,	. . .	6	Over 50, . . .	1
" 20 to 30,	. . .	14		

In 107 cases reliable testimony as to their age at the time of the first outbreak of the disease was obtained, and it was:

Under 10 years, . . .	13 cases	From 30 to 40, . . .	13 cases
From 10 to 15, . . .	30 "	" 40 to 50, . . .	5 "
" 15 to 20, . . .	15 "	Over 50, . . .	5 "
" 20 to 30, . . .	26 "		

The 151 cases in which the date of the first attack could be determined, *i. e.*, 44 seen during first attack, and 107 when a reliable report of age at time of first attack could be obtained, gave the following statistics:

Under 10 years, . . .	20 cases	From 30 to 40, . . .	19 cases
From 10 to 15, . . .	35 "	" 40 to 50, . . .	10. "
" 15 to 20, . . .	21 "	Over 50, . . .	6 "
" 20 to 30, . . .	40 "		

From these tables a large proportion of the cases proved to be first attacked by psoriasis between the ages of 10 and 40, which is what would be expected from the investigations of other observers; but the fact that, out of 151 cases, 20 showed symptoms of psoriasis before the age of 10, was not in accordance with previous experience; and that 6 cases should have been exempt from the disease for the first 50 years or more of their life, was still more at variance with preconceived notions. In 97 cases he had been able to get what appeared to be reliable testimony as to the existence or not of an hereditary tendency. In 31 of these, psoriasis probably had attacked some one of the patients' near relations, and in 66 the patients felt quite sure that such was not the case. This would give the proportion of cases where definite knowledge on the subject was shown as proving the existence of an hereditary influence in about one-third of the number of cases.

The instances in which the writer's observation had confirmed the generally accepted ideas on the subject were referred to, and cases in which he had found difficulty in diagnosis were reported, as was also his experience in treatment.

DISCUSSION.

DR. HYDE, having been told that none of Dr. Greenough's cases had the eruption on the palms of the hands, said that he himself had never seen a case in which the eruption existed on these parts alone. He had seen cases on bald heads, where the patches showed a decided preference for the still hairy portions, never extending more than half an inch beyond the limits of the hair. Itching was, in his experience, often one of the most distressing symptoms of the affection. He had also often observed that the patches were quite as well developed over the sacrum as on the extensor surfaces.

DR. DUHRING alluded to the omission of the reader of the paper to make any mention of the difficulty often met with in making a differential diagnosis between seborrhœa capitis and psoriasis confined to the scalp. In cases of young girls, he himself often found great trouble in making the diagnosis; and several cases which he pronounced to be seborrhœa had afterwards proved to be psoriasis.

Dr. ROBINSON said that, although he agreed with nearly all the statements made by the author of the paper, he would take exception to one or two. He thought that a diagnosis between psoriasis of the scalp and favus was not difficult. When a favus crust is removed, the surface is, as a rule, found to be shiny and depressed, not raw and granular, as was stated in the paper. The latter condition was encountered only in the later stages of favus.

He thought that Dr. Greenough was right when he stated that psoriasis begins as a small rose-colored non-scaly spot. Auspitz taught that psoriasis is primarily an affection of the corneous layer, while he himself held that it is a congestion of the rete.

As regarded pigmentation, he believed that while psoriasis often does pass away without it, yet, when it occurs on the legs, pigmentation often remains after its cure, particularly when varicose veins are also present. He thought that in many cases it is impossible to make a diagnosis between eczema and psoriasis on the legs, for, if the veins are varicose, the scales of the psoriatic patches often look like those of eczema. Very acute psoriasis often resembles acute eczema closely. He once made sections of skin from a case which he took to be one of eczema, and was much puzzled to find the characteristic histological changes of psoriasis, an instance of which disease it afterwards proved to be.

He thought that psoriasis unquestionably does occur on the palms, associated, of course, with the disease in other parts. On the palms it presents no elevated masses of scales, but simply thickening of the skin, the patches being sharply limited. He had also seen patches of psoriasis on cicatricial tissue, and had preserved specimens from such a case.

Dr. WHITE said that to his mind one of the most striking peculiarities of psoriasis of the scalp was the difficulty with which it could be distinguished from dandruff, and that doubt as to the true nature of an eruption situated on this part must often be felt for a long time. This is not the case, of course, when the disease extends beyond the limits of the scalp, when the amount of scale-formation varies according to the personal habits of the patient.

In his experience, pigmentation is often very marked after old psoriasis, not only on the legs, but over the entire body, and he had seen it almost as pronounced as the discoloration left after *lichen ruber*.

He attached but little importance to the seat of the eruption, and was accustomed to place no reliance upon its location as an aid to diagnosis. In his experience the patches were often as abundant on the flexor as on the extensor surfaces, and when they were few in number they were most abundant on the extensor surfaces.

One point which had not been mentioned in the paper was the fact that psoriasis sometimes terminates in verrucous new growths, and these in epithelioma.

Dr. MORISON, alluding to the circumstance that only one of Dr. Greenough's patient was a negro, said that he himself had seen only two cases of the disease in persons of that race. In those, loss of pigment had followed the disappearance of the patches.

Dr. FOX had seen an extensive eruption of psoriasis in a child three and a half years old. He had also seen a case in which the body was covered with the disease, and the extremities were free. He thought that too much stress was ordinarily laid upon the location of the patches,

on the knees and elbows, which, in many cases, are about the only parts spared. Too much stress was also laid upon the "robust health" of the victims of psoriasis, and he had observed that even in seemingly healthy persons the disease always grew worse when their general condition became bad; or, if women, when they became pregnant.

He had found the treatment of the disease much more satisfactory than that of many other cutaneous affections, and he always bore in mind the injunction of the late Tilbury Fox, that "the first thing to do in this disease is to lessen the congestion of the skin." For this purpose he gave alkaline diuretics, although he did not believe in "the gouty diathesis," and thought that the persistent use of large doses of alkalies often do more harm than good. He usually ordered a restricted diet, particularly as regarded meat, especially in hot weather. He also forbade tea, coffee, beer, and tobacco, and advised the liberal consumption of fruit and vegetables. He found that by this course he did more good than by prescribing arsenic or using active local treatment from the start.

As regarded local treatment, he would at present never think of using tar in psoriasis, believing that chrysarobin, used at the right time, was the best of all remedies. It should never be used when the patches were congested and might then cause the disease to spread. In case it did, he believed small doses of calomel and a restriction of the diet until the congestion was lessened would be the best plan of treatment. In many dispensary cases, in whom this plan of treatment had produced no better results than others, he had found that it would soon overcome the disease where the patients were taken into the hospital, where he could be certain that the orders were obeyed.

DR. HEITZMAN said that the most important point to be considered when beginning the treatment of a case of psoriasis was to ascertain whether the disease was acute or chronic. If acute, local treatment should not be resorted to. If chronic, the prospect of removing (not curing) the disease, by local treatment, was good. He had found that the eruption did itch sometimes, and that it occasionally occurred in persons in delicate health.

As regarded the etiology, he thought that even a simple miliaria might run into psoriasis, and he had seen one case in which the simple pressure of the edge of a book held in the hand had caused an eruption of the disease at the spot pressed upon. He did not believe in the causative efficiency of "over-acidity," or of "the gouty diathesis," and thought that we were at present absolutely ignorant as to the true cause of the disease.

As regarded treatment, he thought that alkalies would sooner or later poison the stomach, and never used them. In acute cases he was in the habit of forbidding meat, and using very mild local treatment, often nothing more than an ointment of boracic acid. He could not agree with Dr. Fox in discharging tar for chrysarobin in chronic cases. The latter undoubtedly does remove the disease in some cases, but he agreed with Jarish that it often hastened its recurrence. He frequently employed tar after chrysarobin with the best results. The disease he thought a very unpleasant one to treat, on the whole; in some cases, especially the acute ones, it would continue to extend in spite of all treatment. A particularly obstinate form of the disease was one which Til-

bury Fox had spoken of as a serofulous psoriasis, occurring in sickly persons, a form of the affection in which the patches were small and scattered, and covered with thin scales. He recalled to mind one case of this kind, at Kaposi's clinic, in which the latter hesitated at making a diagnosis between eczema and psoriasis.

DR. TAYLOR also thought that dermatologists were too apt to magnify chrysarobin as compared with tar in the treatment of this disease. In his opinion the former should be used only in cases in which the disease was chronic and localized, and not in the congestive variety. In some cases he had recently had under observation at Charity Hospital he had replaced chrysarobin with oil of cade with very decided benefit. He was convinced that a reaction in favor of tar in the treatment of psoriasis would ere long set in.

DR. HARDAWAY, speaking of the etiology of the affection, said that it was generally admitted that it was often hereditary. He thought that a peculiar kind of skin might be inherited in the same way as a peculiar color of the eye, and that if such were the case, almost any exciting cause, *e. g.*, traumatism, might lead to the development of the disease. He had seen an eczema persist for months and finally terminate in psoriasis; and he had seen an eczema clear up and leave islands of psoriasis behind, and he did not think it remarkable that psoriasis should follow seborrhœa, on account of the prolonged irritation attending the latter affection. Internal causes might excite psoriasis, and he had seen two patients develop the disease after the inordinate use of oatmeal. In its capacity for being excited by internal causes, the disease resembles eczema. In many instances the border line between the two diseases is very indistinct. Wise treatment of psoriasis, he thought, mainly looked towards diet. He restricted the use of meat, aided digestion, etc. Arsenic was useful in some cases, not from its power to remove any internal cause, but from its effects upon the skin itself. Locally, he had found chrysarobin very useful, especially mixed with salicylic acid, as recommended by Fox, especially in chronic cases. He had used tar but little, but often used a sulphur ointment, especially after chrysarobin.

DR. FOX, in answer to a question, said that he added the salicylic acid to the mixture of chrysarobin and collodion, because it softened the epidermic cells. He had found the preparation to act better thus.

DR. WHITE then read a paper on cases of

ANGIOMA PIGMENTOSUM ET ATROPHICUM.

It contained the report of two cases of this rare disease. The patients were brothers, aged fifteen and three respectively, of Russian-Polish family. In the older, the affection exhibited in a striking manner its three principal pathological features, an almost universal lenticular melano-derma, large areas of atrophic integument, and a considerable development of telangiectasiæ. So far as could be judged by the study of these cases, the process is primarily a melasma, the atrophica cutis and new growth of blood-vessels being sequelæ and very subordinate processes in extent.

In the child of three years, the disease was confined to the face and hands, and was represented only by the melano-dermic condition. In neither case was there an apparent beginning of the epitheliomatous change in the skin which so generally forms the last step in this mysterious series of pathological processes.

DISCUSSION.

DR. TAYLOR was entirely at variance with Dr. White as to the relations of the little red spots to the macules, and he spoke from the experience of seven cases observed over an area of years. He had carefully marked the locations of the lesions, and had watched the fading of the red spots and the appearance of brown ones in their places. The only safe way to draw conclusions about this disease was to watch it from its commencement. The history is usually first an obscure rash, then little red spots, and last the macules. He was absolutely certain that the maculation followed the hyperæmia.

DR. HEITZMAN said that in three cases he had studied, the connection between the hyperæmia and the macules was as Dr. Taylor had stated.

DR. GREENOUGH had seen two of Dr. White's cases. In the younger there was no evidence of angioma, the appearance being entirely pigmentary, all stages of discoloration being present. Neither was there any history of vascular dilatation. It didn't seem possible to him that each of the pigmented spots had been preceded by telangiectasis.

DR. TAYLOR said that in his cases the telangiectases were not always visible, appearing only when the parts were exposed to heat.

DR. FOX thought that the two processes of vascular dilatation and pigmentation were entirely distinct, and that it would be better to choose a meaningless name for the disease than the one used.

DR. WHITE said that he recognized a great variation in this disease according to the particular case, but must insist on the correctness of his own observations. He had observed the cases in hot rooms on very hot days, but never found any hyperæmia or chronic enlargement of vessels in the younger case. In the older case there is, at spots, no pigmentation, and there is also no enlargement of vessels. Although the three processes, permanent enlargement of vessels, pigmentation, and atrophy may be associated, they have, as far as individual lesions are concerned, no connection whatever, as far as his observation went.

First Day—Evening Session.

DR. HYDE read a paper on the

RELATIONS OF LUPUS TO TUBERCULOSIS.

The author began with a tabulated statement of all the cases of lupus vulgaris reported to the Statistical Committee of the American Dermatological Association during the last seven years; and compared the frequency of the disease as recognized in this country with that reported from the hernia hospitals, adducing reasons for believing that the American

figures furnished a fair index of the relative preponderance of the disease as it exists in this country.

He then gave details of twenty cases of lupus vulgaris observed by him in Chicago, being the last twenty recorded in consecutive order.

Clinical deductions from these records were then added, showing, according to the author, that there was a remarkable absence in the family record of the twenty patients of cases of pulmonary tuberculosis, scrofula, and allied affections.

The teachings of the two schools, represented in the past by prominent German and French authors, were then reviewed, and finally the later investigations of the subject described, demonstrating that lupus vulgaris was the result of bacillus infection, not to be differentiated in the external characteristics of the parasite from bacillus tuberculosis.

The following clinical facts were then cited in support of the later teaching on this subject, as bearing on the vital point in the author's argument, viz. : that lupus vulgaris was not the result, as has long been taught, of a tuberculosis or other systemic diathesis, but was the product of a local infection by bacilli, entirely unassociated with any constitutional vice, diathesis, or predisposition.

1. The unimpeachable character of the family record in by far the larger number of all cases of lupus vulgaris.

2. The fact that the disease is, in its inception, a disorder of the period of childhood, when, for the most part, the habits of the child are favorable for inspection.

3. The several sites of predilection of the disease are those most liable to such infection.

4. The failure of the disease to spread by inheritance.

5. The remarkable tendency of lupus vulgaris to a cutaneous limitation.

DR. WHITE read a paper on

THE TREATMENT OF LUPUS BY PARASITICIDES.

In this communication he sketched the recent developments in our knowledge which established the common and bacillous origin of tuberculosis, scrofulosis, and lupus, and the rational attempts which have followed to overcome the latter phase of the disease by the external use of parasitocides. He reported the results of these methods in twelve cases of the disease which had been under his observation during the past eighteen months. From these experiments he concluded that we may probably be able to substitute for the painful and unsatisfactory surgical methods hitherto employed against the disease, such very simple applications as are capable of destroying the bacilli in the lupus tissues. Among the most promising of these in his experience were corrosive sublimate and salicylic acid.

DISCUSSION.

DR. FOX said that his experience with corrosive sublimate in lupus was but slight and not so satisfactory as that of Dr. White. He had seen it do good, but was not able to believe that it did so by virtue of its parasiticide qualities, for the reason that it was often of service in causing the disappearance of acne tubercles. He had been surprised at hearing scarification spoken so disparagingly of in the treatment of lupus, as he was convinced that no other plan of treatment would accomplish so much in destroying the new growth, and leaving so little cicatricial tissue. He detailed the case of a young lady with lupus of the nose and cheeks, which had caused ectropion. He had treated her for eight months with scarification, removing the greater part of the disease, obtaining a brilliant result, and that without increasing the ectropion. In other cases, where loss of tissue was less to be avoided, he often used chemical means. Frequently pyrogallie acid, 10 or 20 per cent ointment had speedily removed nodules and diminished the chances of a relapse. The use of mercurial plaster afterwards he thought often did good, and he was of the opinion that a combination of the three measures he had mentioned was perhaps the best plan of treatment.

DR. SHERWELL said that at the risk of being considered too conservative or old-fogyish, he would express his profound disbelief in the theory advanced by Hyde that traumatism, or the contact with dirt from fingers or clothing, could cause lupus. He agreed with Fox as to the melting away of tubercles under mercurials. He believed in the old-fashioned view, that scrofuloderma or lupus means a condition of hereditary syphilitic degeneration.

DR. ROBINSON said that he was undecided as to the connection between lupus and tuberculosis, and could not yet accept the view that the bacillus of the two diseases was the same. Although we know that the lungs are the favorite seat of the bacillus yet lupus cases may go on for years without developing tuberculosis, although constantly inhaling bacilli. Morphological similarity is no proof of identity of nature. Lupus tissue and pulmonary nodules do not correspond, except as to the general characteristics of all infectious granulomata; their situation, mode of spreading, and time and manner of degenerating being different. He did not think that a lupus could ever turn into an epithelioma, which Dr. Hyde had stated to have occurred in two of his cases, since the former has its seat in the corium, the latter in the epidermis; as to the treatment of lupus by parasiticides, he had used mercurials a great deal in this disease for the past six years, and all that he had ever seen accomplished was the rapid breaking down of the central portions of tubercles (never of the periphery), with but temporary benefit.

DR. GRAHAM agreed with the last speaker that the identity of the two affections was not proved. He thought that the case cited by Dr. White, in which lupus was also present in the larynx, was proof of the different nature of the two affections; for in that the patient must have constantly inhaled bacilli, and yet no tubercle developed, although the lungs were predisposed thereto.

DR. TILDEN thought lupus a form of tuberculosis of the skin, although not all tuberculosis of that organ was lupus.

DR. ROHÉ did not believe that oleate of mercury and calomel were

parasitocides. He was now treating a case of lupus with lactic acid with beautiful results.

DR. HYDE said that Dr. Taylor had suggested to him the use of bichloride of mercury and tinct. benzoin. He had used it in lupus and infecting chancre, and had found that, although it caused pain at first, this soon stopped. He thought it a very serviceable dressing. As to what Dr. Sherwell had said about the etiology of lupus, he himself thought inherited syphilis inherited syphilis and nothing else, and that it had nothing to do with any other disease. Dr. Robinson's argument against the identity of lupus and tuberculosis was, he thought, refuted by syphilis, the lesions of which, such as mucous patches and gummata, differ as much as tuberculosis and lupus.

DR. WHITE said that Dr. Fox's statement, that the good work of the bichloride in lupus was not due to its parasiticide action, was refuted by the fact that substances which cause ordinary inflammatory tissue to break down do not cure lupus. When the non-identity of lupus and tuberculosis was attempted to be shown by the fact that the former did not give rise to the latter, he would point to the circumstance that neither syphilis nor leprosy lesions spread to other tissues. This is a peculiarity of all bacillar diseases.

DR. TAYLOR remarked that the ointment used by Dr. White had been employed one hundred years ago, by Sedillot, for the cure of syphilis.

DR. FOX mentioned that he had recently observed the development of tuberculosis of the lungs in a patient suffering from a lupus of the nose.

DR. HARDAWAY then read a paper

ON THE TREATMENT OF PORT-WINE MARK BY ELECTROLYSIS.

In it he stated that, in the treatment of this malady, the object was to excite sufficient inflammation to cause occlusion of the vessels. Electrolysis seemed to be the most convenient way of doing this. At first, he had used a bundle of needles, but after their use the reaction was too violent, and there was also a great tendency to keloidal development, so that he now employed only the single needle. It is important to allow a period of some weeks to elapse between the operations. The histories of three cases were given, in which this method had been employed. In two, the result was very gratifying; in the third, but little was accomplished.

DISCUSSION.

DR. WHITE had recently used the treatment spoken of in the paper in a case of unilateral port-wine mark, and also in others. He could not state that he had produced a complete cure, but great improvement had taken place in all, and in some diseased patches complete obliterations of the vessels had resulted. He had also used the method in cases of rosaceous redness with telangiectatic new growths with marked benefit, which was often but temporary, however, the disease seeming to have a strong disposition to recur.

DR. WIGGLESWORTH thought that not enough stress had been laid

upon the advantages to be derived from cutting the dilated vessels across in two places, and rubbing in a solution of persulphate of iron.

DR. HYDE had used the method recommended by Dr. Sherwell, of tattooing port-wine marks with chromic acid, with good results. When electrolysis was recommended he had used it, and in small telangiectases with good results. But his results with port-wine mark were different. He had found it best, in using this means of treatment, to insert the needle at distances of from one-quarter to one-half an inch. Not long ago a patient applied to him, stating that he was about to be married, and had something wrong with his penis. On examination, he found what he had never before seen, viz., an organ covered with a port-wine mark. It measured nine inches from root to tip, and four and a-half inches in circumference. The glans had a peculiar "peppery" appearance, and the dilatation of the vessels extended down the inner aspect of one thigh. The organ was otherwise normal in all respects, except that when erected it never rose above the horizontal line.

DR. FOX remarked that the so-called "spider cancers" or simple telangiectases were usually readily amenable to treatment, but that it was different with port-wine mark. Over no other disease had he spent so much time and thought in devising an efficient plan of treatment, and in no disease had he so completely failed. He thought that the use of electrolysis was in many instances better than any other plan recommended. He had tried Dr. Sherwell's plan, that of puncturing the patch and rubbing in carbolic acid, before that gentleman had written about it. He was accustomed to pass the needle in obliquely and deeply, in the hope of striking the artery of supply. In nævus of the lip he had often entirely transfixed the part.

DR. SHERWELL said that in some port-wine stains the arterial element seemed to predominate, producing an intensely red patch. In such cases he had frequently had very bad results of treatment. He thought the best results were obtained in cases characterized by lividity of color, in which the venous element was predominant. He had since his first experience with tattooing felt less and less enthusiastic over the value of the method of treatment which he recommended, and was now somewhat tired of it. He had several times seen keloid follow the operation. He had once injected seventeen drops of carbolic acid, and two days later twelve drops into a cavernous tumor on the face of a child five months old. Severe reaction followed, the eye being entirely closed for a few days, but the child recovered entirely. A few days later he had injected twenty-three drops of the same agent into the face of a child seven months old. The practice he thought a very dangerous one, and he would not repeat it, and only did it in those two cases as a dernier ressort.

DR. TAYLOR remarked that port-wine marks on the glans penis and the tegumentary sheath of that organ were not very uncommon.

DR. ROHÉ had seen a cirroid aneurism of the penis.

DR. DENSLOW had recently had a case brought to him of a child three months old, with a vascular tumor on the labium majus, covering also the lower part of the nymphæ. It first appeared at the age of one month, when it ulcerated over one-third of its surface. The ulcer remained stationary for two months. He applied a solution of gutta serena as a placebo, and strange to say, two days later, the entire mass had sloughed out through its entire depth. The ulcer left behind healed

in three weeks. He raised the question whether the compression had had any influence in producing this result.

DR. HYDE thought not. Such ulcerations were common and often sudden, and might possibly be due to a clot in the nutrient vessel.

DR. HARDAWAY said that he believed that up to to-day electrolysis was the most agreeable and successful means of treating port-wine mark. He recommended mopping very hot water upon the part after the operation, as it notably lessened the inflammatory reaction.

DR. SHERWELL then read a paper

ON A MOOT POINT IN THE ETIOLOGY OF PSORIASIS.¹

DISCUSSION.

DR. ROBINSON expressed his belief that the physical condition of the patient had nothing whatever to do with psoriasis. He had seen the disease in chlorotic, anæmic, tubercular, as well as in healthy persons. It was ordinarily an hereditary, purely local trouble, an hyperplasia of the skin.

DR. GREENOUGH held the same opinion, but had found that a very large proportion of those suffering from psoriasis were robust.

DR. HEITZMAN thought that the simple truth of the matter was that we knew nothing whatever about the cause of the disease, and that all speculation about "the rheumatic diathesis, suboxidation, and overacidity of the system" was arrant nonsense.

Second Day—Morning Session.

DR. FOX, by permission of the Association, presented a photograph and read the histories of two well-marked cases of dysidrosis or pompholyx.

The first case, for want of a better term, he classed under this heading. The patient was 29 years old, and had always perspired freely. Four years ago the eruption began on the palms of the hand and had remained ever since. At one time the soles of the feet were also affected. The skin of the hands was thick and of a dark hue, dotted with numerous epidermic elevations, of hemp-seed size. The spots had never been moist, there was no itching, and no desquamation. No fluid was obtained by puncturing the lesions.

The second case was that of a middle-aged woman, of good health. The eruption, of five years' standing, is on the face, and consists of numerous large and small clear vesicles.

DISCUSSION.

DR. DUHRING said that the case whose photograph was shown seemed to be a true dysidrosis, an inflammatory affection entirely distinct from pompholyx.

¹ See page 293.

DR. ROBINSON said that dysidrosis consisted of an obstruction of the sweat ducts in the corium. It might last months or years, the lesions showing no tendency to grouping or spreading. There was no relation between the two diseases, dysidrosis and pompholyx. Sweat acts simply mechanically when retained in the skin, causing no inflammation. Pompholyx closely resembles pemphigus, and is a neurosis.

DR. STELWAGON had seen at least six cases similar to the one pictured in the photograph. He was unable to decide whether they were instances of dysidrosis or sudamina.

DR. ROBINSON then read a paper on

MICROLOGICAL STUDIES IN RINGWORM AND FAVUS.

The first portion of the paper was devoted to a consideration of the conditions favorable to the growth and development of the hyphomycetes or moulds; and the remainder to a description of the anatomical seat of the fungus in the two diseases, the changes produced in the tissues invaded, and the changes, if any, in the surrounding tissues.

He maintained that a suitable nidus from which they can obtain material for their development, together with a free supply of oxygen, moisture, etc., is necessary for their active growth. In defence of the view that a suitable nidus is necessary, and that this condition as a rule is not present in normal epidermis, he said that practically we know that every epidermis is not equally suitable for their growth, that the epidermis of children is a more favorable ground for favus and ringworm than that of adults, whilst the latter is more favorable for *tinea versicolor*. The epidermis of every child is also not equally favorable for the growth of favus or ringworm, neither is that of adults equally suitable for *tinea versicolor*. Some change in the vital energy of the tissues, consisting, as a rule, in a lowered vitality, or in some alteration of its metabolism, is necessary to enable the organisms to develop (Boyd). Practically, we see in the case of ringworm how a lowered vitality of tissue, as occurs in scrofulous or ill-nourished children, is a favorable condition for the growth and development of the fungus as compared with the disease in the robust and well nourished. In the former the disease is very difficult to remove, and it may be absolutely necessary, in order to be successful, to combine internal medication with local means.

With reference to the anatomical seat of the fungus in favus, he never found it to pass into the rete, corium, external root-sheath of the hair or hair-bulb, unless these parts had become structurally changed from pressure or inflammation. In these observations he is in accord with Unna, and against Malassez, Hoggan, etc., who maintain that the fungus penetrates, grows downward through the rete into the corium. It may be present in these situations, but only when it replaces the tissues previously destroyed; it does not grow in the normal, succulent, living tissue.

The depressed centre of the favus scutulum owes its formation in great part, no doubt, to the anatomical relations of the upper epidermis cells to the cuticula of the hair—their close connection and difficulty of elevation by the growing favus mass beneath, as compared with the surrounding epidermis, as already described by Kaposi; but the author believed that another important factor was the structure of the cup itself. The peripheral portion consists of a dense collection of mycelium, imbedded in a granular débris which also contains many micrococci; the central portion, on the other hand, consists almost exclusively of spores which are not very densely packed, hence the peripheral part of the favus cup is much firmer and more resistant to external pressure than the central part and does not so readily sink in.

The fungus elements act locally and mechanically upon the tissues, the epithelial cells and layers are more or less separated from each other, the amount depending upon the amount and situation of fungus present. The rete cells are compressed to a greater or less extent, as also the granular and stratum lucidum layers. In advanced stages of the disease, all these structures undergo degenerative changes and become more or less destroyed; first the corneous layer and then the other layers in succession, either in consequence of pressure from the favus elements or from inflammatory changes proceeding from the corium.

The changes in the hair and hair-follicle area are similar to those in the epidermis just described. The hair-shaft is invaded directly from the fungus lying between the inner sheath and the cuticula, or indirectly by gaining entrance through the cuticula at some point and then passing upward and downward along the shaft, separating the elements. The hair-shaft is also changed in nutrition, even when not invaded by the fungus, and in consequence shows a longitudinal striation caused by air between the fibres—an appearance greatly resembling that caused by mycelium. This appearance, first described by Aubert, is very characteristic of favus, and is not met with, the author believes, in *tinea trichophytina*. Strangely, this author denies the invasion of the hair-shaft.

The changes which occur in the cutis are those of inflammation and retention. The former varies in intensity from the slightest grade to complete destruction of the epidermis and upper part of the corium, or even of its deeper part and substitution by cicatricial tissue. The changes produced by retention are cystic degeneration of the sebaceous and sweat ducts. The rarity with which sebaceous glands are found in cases of favus is noteworthy. The author believes they are very early destroyed by the inflammatory process.

In *tinea trichophytina* the fungus was found in the corneous layer, in the rete, and even in the corium, as well as in the hair and its sheath. In accordance with the view of several English authors, the fungus was

found also upon the free surface, as well as between the epithelial cells. In *tinea trichophytina capitis* the greatest number of fungus elements was found in the hair and the funnel-shaped part of the hair follicle. The cuticula is frequently not invaded in the early stages and sometimes not until the hair is more or less destroyed. The peripheral part of the shaft, excluding the cuticula, is also attacked by preference to the medullary part. The fungus also extends in the hair much further above the free surface than it does in *favus*.

There may be no appreciable inflammatory changes or they may be marked. In the former cases the clinical symptoms may resemble very closely those of *alopecia areata*, and a microscopical examination of the *hairs* be necessary to decide as to the nature of the disease. In *tinea trichophytina barbæ* the same conditions are present as in the scalp, but the inflammatory changes are always decided when the follicle is invaded by the fungus. Whether the fungus penetrates the corium or not could not be decided, owing to the inflammatory changes in the corium in the sections examined, but it is more than probable it does.

In *tinea trichophytina corporis* (*tinea circinata*) the fungus was found in the epidermis and even in the corium in small numbers. But few were found in the hair shaft, although they may be abundant in the mouth of the follicle. The fungus penetrates the corneous layer and may spread by travelling along the free surface or between the corneous layers. Having found a suitable nidus, they grow and multiply and *produce the slight elevation* of the skin observed in ringworm. Unless the inflammation is marked, the lesions of ringworm, the slightly elevated rings, or papules, or indications of vesicles are formed of fungus elements and changed epithelial cells. The changes in the corium may be slight, or there may be sufficient inflammation with exudation to produce vesicles or pustules.

DISCUSSION.

DR. WHITE could not agree with the statement of the author that the disease, ringworm of scalp, was more liable to affect ill-nourished scrofulous children. In his experience, the fungus of this disease exhibited no choice in the selection of its host, he having found it to affect its subjects independently of individuality, it affecting all if given an opportunity, well or sick. Ringworm of the beard, in the vast majority of instances, occurs in perfectly healthy men.

So far as cure of the malady was concerned, he had never seen the necessity of internal treatment, which he would employ only for the reduction of secondary phenomena, but not with a view to the destruction of the fungus.

He was astonished at the stress so often laid upon the so-called vesicular nature of the eruption. He had never seen any vesicles in it, and could never understand why the disease should have been called a herpes.

DR. SHERWELL, speaking of the treatment, said that saturating the scalp with oil he considered a parasiticide measure, it acting by depriving the fungus of air.

DR. PIFFARD agreed with Dr. Robinson as to the systemic conditions usually found in those suffering from ringworm. He considered kerion a disease of the scrofulous, and had never seen it in the robust. He did not consider it a third stage of ringworm, as Dr. White had called it.

DR. DUHRING said that, as to the condition of the soil chosen by ringworm, he had always held that a peculiar condition of the surface was necessary for the propagation of the growth. He did not think that the subjects must necessarily be below par, but had found that they usually were. He did not believe that all persons were subject to ringworm. Some peculiar (unknown) condition of the epidermis must exist to render them liable to it. Robust children get well more rapidly than delicate ones. He had seen true vesicles in ringworm of the general surface.

DR. HEITZMAN agreed with Dr. White that the disease affected the robust as well as the delicate. He had seen strong healthy men covered with ringworm from head to foot. No internal treatment was needed to cure the disease, and he was surprised to hear gentlemen still talking about the system being at fault in the disease. In his opinion there was no basis for any such belief.

DR. DENSLOW had recently seen a large number of cases of the disease occurring on lumbermen of the Northwest, who were usually men of iron. They always recovered without internal treatment.

DR. PIFFARD remarked that chromophytosis occurred twice as often in syphilitic subjects as in non-syphilitic, and he had repeatedly seen it get well under antisyphilitic treatment without local treatment. Whether or not this was the result of the elimination of mercury by the skin he was unable to say. Mosquitoes also showed a preference for certain persons.

DR. HARDAWAY said that, although he had a preconceived notion that ringworm attacked only delicate persons, he had never been able to prove it by observation.

DR. ROBINSON said that, as external conditions made a difference as to development of the fungus, so also did the soil on which it grew make a difference. The disease was much more frequent in children than in adults, and in hospitals some children get it while others do not, and some were much more easily curable than others. It was a well-known fact that the bacillus anthracis could be successfully inoculated in young dogs, but not in old ones. Ringworm untreated gets well at puberty, on account of the fact that the tissues change.

DR. HEITZMAN then read a paper on

THE STRUCTURE OF THE DERMA AND THE DEVELOPMENT OF ELASTIC TISSUE IN IT, WITH DEMONSTRATIONS.

In it he stated that the derma is made up of interlacing bundles of so-called fibrous connective tissue, which are comparatively coarse in the middle and lower portions of the derma, and delicate in the papillary layer. The bundles look striated, owing to the presence of dense spindles, representing the glue-yielding basis substance proper, being united with

each other by a less dense, so-called cement substance. Real fibres appear only after teasing or after application of chemical reagents. Between the bundles lie the protoplasmic cords, freely supplied with nuclei, and, according to the general spindle-shape of the bundles, branching and connecting everywhere. Isolated cells or connective-tissue corpuscles do not exist in the derma, nor in any other variety of fibrous connective tissue, such as tendon, aponeuroses, ligaments, etc. Starting from the protoplasmic cords, delicate offshoots pass into the bundles and freely connect with an extremely delicate reticulum of living matter which traverses the basis substance to such an extent that only the meshes of the reticulum contain the glue-yielding basis substance. The delicate interstices between the spindles or fibres, the cement substance, is again traversed by minute spokes of living-matter. Thus the whole basis substance is endowed with properties of life, and in inflammation the formation of inflammatory or eventually pus-corpuscles, though starting from the protoplasmic cords, goes on from the latter as well as from the bundles.

With advancing age, the interstices between the bundles, filled with protoplasm, decrease in size, whereas the volume of the bundles increases. The interstices at length become reduced to narrow slits, and at the edges of the bundles, where the contact between them is narrowest, a very dense elastic basis substance forms, assuming the shape of elastic fibres. The branching of these fibres becomes intelligible only by assuming a direct transformation of the protoplasm into elastic substance along the edges of the bundles. In some benign tumors of the skin, such as fibrous papilloma, etc., the formation of elastic tissue goes on in a rather premature and rapid manner. All the three varieties of basis substance of the derma, the glue-yielding, the cement, and the elastic substance, are direct products of protoplasm, and all of them are possessed of properties of life.

DR. HARDAWAY read a paper on

MULTIPLE MYOMATA OF THE SKIN—ILLUSTRATED.

DISCUSSION.

DR. DUHRING said that the form of the lesions resembled a case of his own which had been alluded to in the paper. He thought that clinically it was very difficult and even impossible to make a diagnosis of the true nature of the affection. In his own case (which was a true neuroma), the pain was intense on slight, but relieved by firm pressure.

DR. HEITZMAN said that the specimen under the microscope showed that the derma was almost entirely transformed into myomatous tissue. He had seen only one specimen of the kind in his laboratory in ten years. He believed that the pain of which the patient complained was not due to a new-formation of nerves, but to the pressure of the growths upon

already existing nerves. The specimen shows that no new-formation of nerves is necessary in order that a tumor may be painful. A myxoma, myoma, or a chondroma may be painful.

DR. MORISON next read a description of

A CASE OF TYLOSIS OF THE HANDS.

A negro, aged 32 years, had both hands much affected with this disease. He was a fireman on a steamer, and had been working as such for ten years. The constant rubbing of the hands upon the handle of the shovel had caused callosities and subsequently ulcerations. On the left hand the ulcerations were followed by loss of tissue and bone, so that it was very much deformed. The third phalanx of two fingers was entirely gone, and the other fingers were in a state of disease which showed their ultimate demolition. The thumb of the same hand had a patch of ulceration upon its inside surface, which in a few weeks exposed the first joint, the bones becoming necrosed. The ulcerations started first as callosities. There was absolutely no pain, nor had there ever been any. The man picked out pieces of bone himself and threw them away. He had no history of syphilis, was muscular, healthy, and without any disease anywhere else on the body. No treatment, excepting rest, was advised; but the patient, as long as he suffered no pain, was not willing to give up his lucrative occupation.

Plates were shown illustrating the condition of the hands at that time.

DISCUSSION.

DR. WHITE said that the result of the disease was so extraordinary that he was strongly inclined to believe that there was some antecedent change in the system of the patient to cause the necrosis of the bones of the fingers.

DR. TILDEN thought that the disease in this patient bore a strong resemblance to the "*mal perforant du pied*" of the French. He also said that the case reminded him of *lepra mutilans*.

DR. DUHRING expressed the opinion that there must have been some deep-seated nervous change in the system of the patient, such as occurs in perforating ulcer. He did not believe that simple local irritation could excite such destructive changes.

DR. MORISON said that he had been unable to find any evidence of disease of nerves in the case, and that the local irritation was the cause of the trouble was shown by the circumstance that the left hand which ran up and down the handle of the shovel used in the man's occupation was much more severely affected than the right, which simply grasped the handle of the instrument.

Evening Session—Second Day.

DR. DUHRING read a paper entitled

THE RELATION OF HERPES GESTATIONIS AND CERTAIN OTHER FORMS OF DISEASE TO DERMATITIS HERPETIFORMIS.

Attention was briefly directed to the previous article of the reader on dermatitis herpetiformis, and to a paper showing its identity with the impetigo herpetiformis of Hebra; also to a preliminary note on the relation of this disease to herpes gestationis and other similar forms of cutaneous disease, read before the Association at the last meeting.

The object of the present communication was to prove the identity of so-called herpes gestationis with the vesicular variety of dermatitis herpetiformis, and to show that the term herpes gestationis is a misnomer, the affection being found in men as well as in women. Secondly, that certain other so-called forms of herpes, such as "herpes pemphigoides," "herpes vegetans," "herpes pyæmicus," etc., as well as certain cases regarded by the reporters as "peculiar forms of pemphigus," must be viewed as examples of this disease; and, finally, that instances of the same affection are also met with in literature under the title of hydroa, and under divers other captions. Numerous cases from English, French, and German literature were cited. The paper of Dr. Duhring was stated to be looked upon as supplementary to the preliminary notes referred to, and embodied the results of considerable research into literature. If the views put forth proved to be correct, a great deal had been gained for dermatology in bringing these peculiar forms of disease together.

DISCUSSION.

DR. WHITE remarked that since the last meeting of the Association he had seen five cases of dermatitis herpetiformis, two of which he had treated. The more he had seen of the disease, the more he thought the title given it by Dr. Duhring a misnomer. He thought it should be called dermatitis multiformis, as he had found that the herpetic element was only exceptionally present, being entirely absent in some cases. He had never seen a case of the disease which he would have been apt to confound with herpes, though he had seen some which he might have taken for eczema or pemphigus. The vesicles, in his experience, always failed to present the tendency to grouping so characteristic of herpes.

DR. ROBINSON held the same view as the last speaker. He had seen five or six cases of the disease. He thought the name hydroa a sufficiently comprehensive one, and not misleading, as long as we know no more of the affection than at present. He thought the inflammatory changes met with were secondary to some internal derangement.

DR. HYDE thought the term herpetiform preferable to the others which had been suggested, since tradition favored it, as shown in the well-known name impetigo herpetiformis. Although he fully recognized

the multiform character of the lesions, yet, in the cases he had seen, there was an unmistakable suggestion of herpes.

Dr. Fox exhibited a photograph of a case which might be mistaken for herpetiform dermatitis, although it was a well-marked case of multiform erythema. He, too, did not like the name given the disease by Dr. Duhring. In his case there were vesicular and bullous lesions and typical patches of herpes iris, and in one place it showed an annular bulla, made up of a circle of vesicles which had coalesced.

Dr. DUHRING could not agree with the other speakers in their objections to the use of the term "herpetiform." This characteristic was present in a more or less marked degree in all the cases, and the term was, therefore, both appropriate and expressive. Hebra recognized the herpetiform nature of his cases, and a thorough search of the literature of the subject had taught him that almost all writers on the subject did likewise. He had used the term multiform dermatitis to distinguish one variety of the affection, and that a very important one. The adjective did not, however, seem to him sufficiently expressive. He did not consider the disease a rare one. He thought that we stood on the threshold of our knowledge of the disease, and he himself was constantly learning something new about it. It was an immense process, capable of indefinite elaboration, which will be done as time goes on. Cases varied greatly as they presented themselves, as would naturally be expected in so elaborate a process as the affection represented.

(To be concluded.)

Selections.

HERPES TONSURANS MACULOSUS.

THE name herpes tonsurans maculosus is given to an acute eruption disseminating more or less over the entire body, and caused by the vegetable parasite, the *trichophyton tonsurans*. It is comparatively infrequent in its occurrence here, and though it has a common origin with ordinary ringworm, yet it differs from this in the manner of its invasion, the acuteness of its development, the extent of surface implicated, and in its general course. The individual lesions retain, however, the salient characteristics of the ordinary form.

The conditions under which it may occur are the same as those favoring the development of ordinary ringworm, viz., damp lodgings, clothes, etc.; immediate infection, etc. In none, however, of the many cases which I have observed, have I been able to trace its having been communicated from one person to another, even though all conditions for such communication were present.

In all probability, an outbreak of herpes tonsurans maculosus is due to multiple infection. The spores of the parasite, obtaining access to the skin at many points, develop rapidly under suitable conditions. The primary lesions thus formed may again serve as foci of the infection, inasmuch as the scales of epidermis, being detached by the movements of the body, carry the spores to other as yet unaffected portions, where the process begins anew. A succession of out-

breaks thus appears until, in a short time, the patient is covered with the lesions in all stages of development.

There is no particular localization to the disease, and no portion of the body is invulnerable to its attacks. The outbreak of the affection may be preceded by malaise, some fever, loss of appetite, and symptoms of general disturbance. In the course of the disease, the irritation and consequent loss of sleep in children may give rise to serious anxiety.

The eruption first appears in the form of pale-red papules about as large as a millet-seed, which disappear on pressure, and are slightly elevated. On parts where there is much perspiration, the color of the lesion is a dark-red. Shortly after the appearance of the papules, peripheral growth has ensued, and slight exfoliation will be observed in the centres, while the edges remain smooth and red. The lesions are at first circular, but, as they grow larger, many become oval in shape, their long axes lying in the direction of the cleavage lines of the skin. Their development is at first rapid, and in the course of a week or ten days they attain the size of a twenty-five cent piece, or even larger. When the edges of two or more of the lesions come together, the portions which were in contact disappear, and a gyrate form of eruption remains. As the lesions increase in size, their edges become more elevated, are of a bright-red, and scaly, fading gradually away into the surrounding tissue. At times vesiculation is observed. The central portions are more or less scaly and in process of involution, but in the larger lesions these squamæ have ceased forming, and the skin may be found perfectly normal. As they become older, they acquire a dirty, light-brown color, and they approach more nearly to a typical ringworm. Many of the lesions, however, do not follow this course, but abort and disappear a few days after their first appearance. The itching of the eruption, in uncomplicated cases, is not very severe.

If left to itself, the disease runs its course in from two to six months. The edges flatten out, the erythematous condition disappears, desquamation occurs, and the skin becomes again normal. Slight pigmentation may remain for a variable length of time. One spot often remains, especially on those parts of the body which are well protected, and may serve as a focus for reinfection. On microscopical examination of the epidermis scales, the mycelia and conidia of the *trichophyton tonsurans* will be found but very sparingly in the younger lesions—contrary to what occurs in ordinary ringworm. As the lesions, however, become larger, and approach more nearly to the type of the later disease, the presence of the parasite is easily demonstrable.

The diagnosis presents no special difficulty, if the distinguishing characteristics of ordinary ringworm are kept in mind. Only at its first appearance can it be mistaken, and its development is so rapid that ordinary observation very soon clears up any doubt as to the nature of the eruption. Should an eczema complicate the case, the finding of a fresh and uninjured lesion will demonstrate the real disease present.

The treatment is in substance the same as that used in the other forms of disease caused by the *trichophyton tonsurans*. It should be borne in mind that it is absolutely necessary to apply the anti-parasitic remedy to the whole body, even upon those portions which appear perfectly normal. It is important to check the progress of the disease as quickly as possible, and the longer it is temporized with, the greater the difficulty in curing it, and the greater the risk that an eczema or a dermatitis may arise to complicate it. After the arrest of the affection, and there is a certainty of the death of the parasitic spores, the skin should

be protected by the inunction of some bland salve, and powder should be freely used. More or less exfoliation of the epidermis occurs, and the skin becomes normal in from a week to ten days.—GEORGE T. ELLIOTT, *N. Y. Med. Journ.*, July 4, 1885.

PUMICE-STONE IN PITYRIASIS VERSICOLOR.

OF the numerous remedies proposed for the cure of this affection, such as the lotions of nitric acid, of sulphur, and of borax, the pomades of mercury and tar, none rivals a soap made from pumice-stone in destroying the microsporon. The action of the alkali contained in the soap upon the skin, together with the mechanical effect of the powder of pumice-stone, is certain to produce the desired result. Prolonged frictions should be made morning and night with soap prepared according to the following (Vigier's) formula:

Black soap.....	lb. ij.
Pumice-stone.....	lb. ss.
Mix carefully.	— <i>Ther. Gazette</i> , July 15, 1885.

Review.

LEHRBUCH DER HAUT- UND GESCHLECHTSKRANKHEITEN. Von DR. EDMUND LESSER. Erster Theil. Haut-Krankheiten. Leipzig: F. C. W. Vogel, 1885.

This book belongs to the class of minor works which aim to give in brief a complete conspectus of the subject.

In most respects, the author successfully carries out his object. His description of the various diseases, though concise, are accurate and excellent. Histological considerations are omitted as regards the majority of affections of which he treats, and when given, are exceedingly brief. He enters more fully into etiological questions, but, in the main, from standpoints which would not be considered sound by the majority of dermatologists of this country. In the matter of treatment, the book is specially defective, the author appearing to be uninformed as to the various methods in vogue in other, and especially in this country. As a whole, the work may be considered as a foundation on which the author can, in a second edition, if he chooses, build a useful and instructive treatise.



Dr. Ripley's case of Bullous Eruption in a child.

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CASE OF BULLOUS ERUPTION IN A CHILD.

BY

J. H. RIPLEY, M.D.

WALTER M. was a fair-haired, bright boy, 4 years old, and born of exceptionally healthy parents. His maternal grandmother suffered from attacks of chronic rheumatism, and a paternal aunt had died of "hasty consumption." Otherwise, so far as known, there was no hereditary tendency to disease in the family. Of the four children, this boy, an older sister (10), a younger brother (3), had all three been subject to frequent attacks of urticaria. The other child, also older (7), had escaped. Four weeks previous to the present illness, Walter had had a mild attack of measles which was immediately succeeded by a sharp and persistent attack of urticaria. This lasted, intermittently, for over two weeks. As it was apparently finally declining, circumscribed areas of violent dermatitis appeared successively on different parts of the body. Only the palms of the hands and the scalp proper remained uninvaded. The first patch, pear-shaped and about five inches long, appeared on the outer aspect of the right thigh. The epidermis was soon lifted by serous exudation and a large bulla formed. At first the contained fluid was clear and transparent, but rapidly became turbid. Invasions of new areas speedily followed, each succeeding day developing new crops of bullæ, the disease showing at first a preference for the buttocks and lower extremities; later the upper extremities, neck, face, and even the mucous membranes of the nose and mouth.

The blebs varied much in size and also in shape; some were nearly circular and from the size of a ten-cent piece to that of a trade-dollar;

others were ovoid, triangular or rectangular, and several inches long. The dorsum of the right foot was completely covered with a single bleb. The back of the right hand, including the fingers as far as the nails, was covered with one continuous vesicle. The entire back of the neck was involved. The gluteal and perineal surfaces were entirely covered, the inflammatory process even extending half an inch inward, over the mucous membrane of the rectum.

The disease lasted about two weeks, and for several days during its height the constitutional symptoms were alarming. The stomach was so irritable that only small quantities of the simplest liquid food could be tolerated. The temperature, which earlier had ranged from $101-2^{\circ}$, now rose to 104° , and there was great prostration and at times muttering delirium. The boy would lie for hours without moving a limb, and much urging was required to induce him to take nourishment. As nutrition became impaired, the skin exudations consisted more and more largely of blood; some of the blebs looked as though they contained pure arterio-venous blood. Extreme fragility of the walls of the blebs was generally associated with bloody contents, became early ruptured, and tearing away of the protecting epidermis generally took place, leaving large bleeding surfaces which were difficult to manage. Hemorrhages occurred also from the mouth, nose, rectum, and from beneath the finger and toe nails. At this time the patient was a pitiable sight. He had rapidly lost flesh, his eyes were sunken and dull, his little wasted hands trembled like an aspen leaf whenever he attempted to raise a cup to his lips. His body, limbs, and head were covered with sores which were only partly hidden by the blood-stained dressings.

His recovery was protracted but complete. The most satisfactory local application was dry bismuth (subnitrate). It was soothing, hæmostatic, and not easily removed except by intention. It was dusted over the parts by means of a powder gun, and removed not oftener than every other day. Internal treatment consisted of the muriate tincture of iron in small doses three or four times a day (sometimes it could not be tolerated for days together), and occasionally quinine in large doses. In regard to nourishment, the most simple liquid food (for a while Murdock's) only could be borne, and hypernutrition was made impossible on account of the great irritability of the stomach. Those nails which had been the seat of hemorrhage into their beds (before mentioned) lost their vitality, came away, and were replaced by new and healthy ones.

Dr. W. T. Alexander saw the case with me when at its worst, and believes it to have been a case of "*acuta pemphigus vulgaris*" as described by A. R. Robinson.¹ It certainly was a bullous eruption.

¹ "A Manual of Dermatology." New York, Appleton & Co.

BROMIDE OF ARSENIC IN ACNE.

BY

HENRY G. PIFFARD, M.D.

DURING the past two years, I have met with various paragraphs in the press to the effect that bromide of arsenic was a "cure" or "sure cure" for pimples, and crediting the assertion to me. The last of these that has met my eye is taken from the *Medical Age*, and reads as follows:

"BROMIDE OF ARSENIC FOR PIMPLES.—It will be a great relief to suffering thousands to learn, on as good authority as Dr. Piffard, that the bromide of arsenic is 'a cure for pimples. He recommends a one-per-cent solution, of which one or two minims are to be taken in a wine-glassful of water three times a day, on an empty stomach. The dose is to be diminished as the pimples begin to disappear."

I have, in addition, received numerous letters from physicians asking for further information relative to the uses of the drug in question. In reply I can only say that I have never asserted that bromide of arsenic was a cure for pimples, or anything else, and that the only authority for the paragraphs will be found in the following extracts from my published writings:

"The use of bromide of arsenic is, I believe, original; at least, I have not met with any reference to it in literature. Conceiving, from purely theoretical considerations, that it might be useful in certain cases, I first tried it in the spring of 1878 in a case of pustular acne vulgaris of moderate severity, and gave it in doses of one milligram (gr. $\frac{1}{65}$) three times a day. Within a week the patient, a young lady, returned, complaining that her face was much worse. On examination, I found on each side of the face a crop of miliary pustules in addition to the acne. The arsenic was discontinued, and a placebo prescribed. This was followed by improvement for a week, when the arsenic was resumed in much smaller doses, and in three or four weeks the case was substantially well. In a second case I had a similar experience, and in a third case I prescribed an alcoholic solution containing one grain to the ounce, and directed that two drops should be taken night and morning. This patient I did not again see for nearly six months, when she informed me that the medicine had in a few weeks accomplished all that she desired. Since then I have used bromide of arsenic with much satisfaction in pustular acne, but have not tried it in other varieties of this affection, nor in other cutaneous diseases."—*Mat. Med. and Ther. of the Skin*, 1881, p. 28.

"The bromide of arsenic occupies a middle ground between arsenious acid and sulphide of calcium, and is probably adapted to a greater number of cases than the drugs just mentioned."—*Ibid.*, p. 137.

"Next in usefulness is bromide of arsenic, given in doses of from $\frac{1}{100}$ to $\frac{1}{50}$ of a grain. A one-per-cent solution in alcohol is a very available method of dispensing it, and the dose will be one or two minims (not drops) in a wineglass of water two or three times a day. If any gastric irritation should ensue, the dose should be lessened. The repetition of the dose, and the continuance and discontinuance of the drug, are to be governed by the same rules that apply in the case of calx sulphurata. As regards the choice between the two drugs mentioned, I can say but little, other than that it has been my custom to use the former drug in cases of a lymphatic character, and the latter in those of a more florid type."—*JOURN. CUT. AND VEN. DIS.*, March, 1884.

ON THE RELATIONS OF LUPUS VULGARIS TO TUBERCULOSIS.¹

BY

JAMES NEVINS HYDE, M.D.,

Professor of Skin and Venereal Diseases, Rush Medical College, Chicago.

IN order to arrive at trustworthy conclusions respecting the nature and relations of any disease, it is necessary to study its phenomena from both the clinical and pathological standpoint. In the case of lupus vulgaris, this study has been conducted by those whom we recognize as having brought to the task all due skill, diligence, and conscientiousness. It is none the less needful, however, to compare from time to time the results thus obtained with those acquired by personal experience.

Reviewing the returns collected by the statistical committee of the American Dermatological Association, we find that from the year 1878 to 1884 inclusive, 350 cases of lupus vulgaris came under the observation of members furnishing these returns, of which number 124 cases occurred in private and 226 in public practice. From the accompanying table, showing the number of cases reported from the several districts, it appears that New York is credited with the largest number, viz., 120; Chicago the next, 99, and the other districts, respectively, Boston, 67; St. Louis, 28; Baltimore, 16; Philadelphia, 13; and Canada, 7.

¹ Read at Ninth Annual Meeting of Am. Dermatol. Assoc.

Table of Statistics of Lupus Vulgaris as reported to the American Dermatological Association.

Years.	Boston.	New York.	Philadelphia.	Baltimore.	St. Louis.	Chicago.	Canada.	Priv. Practice.	Pub. Practice.	Total.
1878..	21	3	1	8	2	7	—	13	29	42
1879..	10	6	1	—	3	16	—	16	20	36
1880..	8	22	1	1	5	17	—	20	34	54
1881..	8	13	8	2	6	14	—	15	36	51
1882..	6	24	1	4	6	12	3	26	30	56
1883..	8	34	1	1	—	15	2	15	46	61
1884..	6	18	—	—	6	18	2	19	31	50
7 yrs.	67	120	13	16	28	99	7	124	226	350

It is reasonably certain that these figures, rather than those set opposite the names of several other disorders, furnish a means of arriving at some knowledge of the relative frequency of the disease as tabulated in this country. For, first, lupus vulgaris, being an unusually chronic malady, is one particularly likely at some time or another in its progress to drift from the hands of the general practitioner into the management of the expert; second, its formidable features prompt the average physician at an early period to consult the dermatologist respecting its nature and therapy; and lastly, the poorer class of patients, often failing to secure relief from the very best of treatment, are impelled at one time or another to visit the public charities, where such cases are assigned for treatment to special departments. Briefly, it may be said, that for one case of lupus that chances to escape the eye of the expert, there are hundreds of cases of eczema that never come under his observation. Making due allowance, therefore, for errors of diagnosis and of record, it may be assumed as reasonably certain that the figures given above nearly represent the relative frequency of lupus vulgaris as it exists in this country.

Many of the cases reported from the Chicago district came under my personal observation. Twenty cases only, however, are collated for illustrative purposes in this paper, being those last observed in a strictly consecutive order. In making up the list, it was deemed best to exclude all patients who were exclusively examined at the public clinic, the record being then generally less full than in the case of those observed in private practice, though occasionally, after a first appearance at the clinic, one or more of this class of patients were subsequently examined in private, and their records included in the list. The cases where the diagnosis was doubtful or obscured by co-existence of syphilis are excluded,

save in the few instances where special attention is directed to the reasons for such exception.

As the lesions of lupus vulgaris in its several forms are well understood, and have been again and again illustrated by all the devices known to art, the following records include merely the briefest outlines of each case, with special reference to the points in each, throwing light upon the subject under consideration.

CASE I.—A. P., American, male, unmarried, aged 28 years; profession, attorney. Sept. 9, 1881.

This patient had a typical, irregularly circular, orange-sized patch upon the left cheek, involving a part of the lower lid of that side. It was made up of softish tubercles of reddish-brown hue, deeply imbedded in the skin, ulcers, crusts, and cicatrices. It had existed since early life, beginning in the fifth year, but had largely spread during the last decade. Its origin had been referred by his family to a traumatism. It had been treated by repeated cauterizations. There were no venereal antecedents, and his family record contained no history of tuberculosis or struma. He was a man of average stature, weight, and development, complaining chiefly on account of the visual disturbance induced by the irritation starting from the involved lid.

CASE II.—A. R. S., American, male, aged 52 years, but still vigorous, well nourished, and active. Married twenty-seven years, with one married daughter having healthy children, all carefully examined. Two of his children died of infantile disorders.

Nov. 16, 1881, he exhibited a palm-sized patch on the left cheek made up of sub-epidermic tubercles of dark ham-color, an infiltrated, desquamating integument, central irregular cicatrices, and the lobe of the left ear agglutinated to the corresponding part of the cheek. The patient was a man of wealth and position, free from venereal antecedents, and his family record showed no trace of cutaneous disease, tuberculosis, or struma. He was a ship-chandler by occupation, and had led an active life, never having suffered from other malady of consequence. The disease dated from the sixth year of life, beginning with "lumps which burst, and ran, and left scars," one of the latter being still visible near the ear. There was a history of traumatism at that early period, also of another occurring in the twentieth year in the site of the involved patch, which had considerably aggravated it. He had been treated with repeated cauterizations, and the knife had been used once in an effort to remove the diseased patch.

As he improved somewhat under treatment, he was lost sight of till 1883, when he re-appeared with a characteristic, thin-edged, soft-floored, and crusted ulcer centrally situated in his patch of disease, and distinctly surrounded by softish, dark-red tubercles. This was treated by caustic potash and other destructive agents, which failed to induce cicatrization, the patch slowly extending. In 1884, the disease having now lasted nearly half a century and the patient being fifty-five years of age, a marked change occurred in the cheek. It was then the seat of a single ulcer, which, as it spread, destroyed all signs of other disease, and rolled out a thick, everted, glazed, and reddish edge. It was then twice thoroughly curetted and after each operation well-nigh cicatrized, but recurred

after each, presenting finally the typical aspect of a malignant epithelioma. This man is now dying, exhibiting characteristic cancerous cachexia, a gigantic ulcer in the cheek, which has destroyed the larger part of the ear of the left side, a portion of the left eye, the larger part of the malar bone of that side, three-fourths of the lower maxilla, and a corresponding part of the soft parts of the face.

This patient, in an advanced stage of ulceration, was shown by me both to Dr. E. L. Keyes, of New York, and to Dr. L. A. Duhring, of Philadelphia, each of them stating that there was no evidence present of lupous involvement. I have, however, not hesitated to set down this case in the same category with the others, as its early history and features point unmistakably to a disease preceding the epitheliomatous change, lupoid in character, and decidedly less malignant in type than that which followed.

CASE III.—W. B., aged 37 years, married thirteen years, English, male, stationer, with one living child, which was examined and found to be in sound health.

Dec. 15, 1881.—Patient stated that he had been born with the present disease, which is probably, therefore, to be referred to an early period of infancy. It began as a "red spot" under the chin, which constantly spread and troubled him; but since his coming to America, a similar spot appeared on the left buttock, which proved to be greatly annoying in that locality. He had been under the professional care of Mr. Startin, of London, who pronounced his case to be *lupus vulgaris*, and who had given him a paint which he applied with some relief. He admitted having contracted a gonorrhœa in his youth, but no other venereal disorder.

Beneath the chin was a small palm-sized ulcerated and crusted patch, carefully covered with the reddish hairs of the beard. On the left buttock, was a large platter-sized, exulcerated, crusted, thin-edged, only partially cicatrized patch, presenting the same general features recognized in the patch under the chin. There were numbers of tubercles in each which had not broken down. The condition of the patient was most distressing, as he could not occupy, when seated, the usual posture required for that attitude.

The notes of this case are quite full, and supplemented by voluminous letters written after the patient passed from observation. The case is noteworthy on account of the fact that he presented a picture of sound health not often to be recognized in the subjects of this disease. He weighed one hundred and sixty-two pounds, had remarkably florid cheeks, stout muscles, and was able to attend to his business with regularity and success. There was no history of tuberculosis in any member of his family. He was last seen by me Nov. 14, 1882.

CASE IV.—Mrs. L. S., a Jewess, aged 49 years, married twenty-nine years, mother of six children, all healthy, with married daughters, who were themselves mothers of sound children, sought advice May 26, 1881. She stated that she had suffered from the present disease since her earliest recollection in childhood. It had never disappeared, and had slowly increased in severity and extent. She was an enormously fleshy woman, with a huge pendulous belly, which, when she was seated, rested upon the thighs. The entire lower part of this belly and the upper third of the left thigh was the seat of an enormous cicatricial patch, irregularly

marked with depressions and ridges, and limited peripherally on the upper part of the abdominal area and at the edge which encircled the thigh, with a serpiginous ulcer. This was linear in general form, crusted here and there, secreting actively at some points of the ulcerated surface, and tolerably well defined by a narrow border. The ulceration had begun to attack the outer fold of the left labium majus. For years she had sought merely palliative treatment, having had a wide experience of all others. There was no history of struma or tuberculosis in her family record.

CASE V.—W. H., male, unmarried, aged 29 years, resident of Illinois, applied for relief June 6, 1882. There was an egg-sized ulcerated patch in the centre of the left cheek, surrounded by deeply imbedded tubercles, a few having lately broken down on the upper edge. At one point the ulceration had attacked the lower lid of the left side, and the annoyance of this led him to seek aid. The disease had existed from an early period in life; he could not assign an exact date to its origin. This patch was treated by multiple linear scarifications, several times repeated, with decidedly favorable results, evident in the course of two months. After that time he was in charge of his local physician. There was no history of venereal antecedents or of other diseases of gravity; and no trace of tuberculosis or struma in his family record. Parents and two sisters living and in good health, one of the latter examined. He weighed one hundred and fifty-six pounds, was well nourished, and engaged in business.

CASE VI.—N. N., female, aged 38 years, wife of a farmer, married in all sixteen years, having had two husbands without pregnancy occurring. She applied for advice, Aug. 1, 1882.

The disease began in her seventh year on the upper lip and nose, and had gradually extended till the two regions were involved in an irregular ulceration, surrounded by tubercles, and characterized by a thin edge, a softish floor, and a scanty secretion.

She belonged physically to a class of people seen often among the farmers' families of the Western interior. She was thin, sallow, of decidedly nervous temperament, and poorly nourished. But she could give no history of tuberculosis or struma in her family. Her father had been drowned; mother, living, aged sixty-five, and in good health. There were six living brothers and sisters, all reported to be healthy.

CASE VII.—S. E., farmer, aged 28 years, unmarried. Came for advice Sept. 15, 1882. His disease began near the tragus of the left ear on the right side, where was a silver-dollar-sized patch, made up of scar-tissue and ulceration. The lobe of the ear was involved to the extent of three-fourths of its substance; the external auditory meatus was closed by reason of infiltration of tissue. He gave a history of submaxillary adenopathy when a boy, and of some sort of swelling in the region of the shoulder of the same side, which had been, as he reported, "absorbed," without leaving a scar. The hearing distance of the involved ear was reduced to contact with the watch.

The patient was fairly well nourished, gave no history of venereal antecedents or of other disease of consequence; and the family record contained no evidence of tuberculosis or struma. Parents both living and reported well; one only of their five children dead of some infantile disorder.

CASE VIII.—M. P., German, female, unmarried, aged 22 years, presented herself first at the clinic, with an unmarried sister, May 11, 1882. Her disease was reported as having first appeared in early childhood. She exhibited a large palm-sized patch on the right side of the cheek, involving also the entire side of the nose adjacent, made up of ulcers, crusts, tubercles, and centrally situated scars. She gave a very clear family record extending to the grandparents of both sides, without record of tuberculosis or struma. She was a fresh-looking, light-haired, blonde woman, remarkably well nourished, with well developed figure, and presented all evidences of sound health with the exception of her facial disfigurement.

CASE IX.—F. H., a Jewess, 19 years old, came with her parents, May 11, 1883. She had suffered from the present disease, according to the statements of her parents, for only a few years past. She was a thin, pallid, narrow-chested, sallow-faced girl, apparently ill-developed, who had been menstruating four years. Both father and mother were small, sallow-faced representatives of their race; but they reported their two other children as quite healthy, and could give no family record of struma or tuberculosis. The nose of the girl was the seat of an ulceration involving the tip and alæ, surrounded by purplish tubercles, some quite prominent; and there was an attempt at scarring only on the right side. The patient returned in the course of the next year, greatly improved in appearance, the sore having completely cicatrized in its entire extent, her weight having increased, her color exhibiting a decided change for the better. She had been treated by iodine, and cod-liver oil internally, with vigorous stimulation of the sore. Father, aged forty-eight years; mother, forty-seven; there had been one miscarriage in the second month of pregnancy, resulting from accident.

CASE X.—M. G., female, aged 42 years, married twenty-one years, sought advice, July 23, 1883. An irregular patch of scars, ulcers, and crusts, was visible on the left cheek and on the side of the nose, as large as a silver dollar. It had existed since the tenth year of life; and had therefore endured for thirty-two years. It had troubled her more since her marriage than before that date, having been decidedly worse since the thirty-first year of her life. She had two living children, reported to be healthy; and two dead, one of diphtheria at the seventh year of age; the other of cholera infantum, in infancy. There had been one miscarriage, the cause of which was unknown. No family record of tuberculosis or of struma.

CASE XI.—G. W. The case of this patient, a male, aged 30 years, is familiar to most dermatologists by reason of the excellent photograph of the patch of disease on his cheek furnished in the admirable collection published by a member of this Association, Dr. George Henry Fox, of New York. It appears in both editions of the atlas¹ referred to.

After placing himself in the charge of several dermatologists of repute, this man presented himself to me once, in 1883, at which time I had the opportunity of making a personal examination. He appeared somewhat older than at the time when his picture had been taken. The disease was unchecked in the cheek, and his general health was rather less fa-

¹ "Photographic Illustrations of Skin Diseases," New York: E. B. Treat, 1879, p. 55.

vorable than before. As the notes of the case are published by Dr. Fox, I merely refer to them in this connection.

CASE XI.—I. J., male, aged 12 years, came from the country in a district near Chicago, Sept. 10, 1883. His parents said that the disease with which he was afflicted had existed from earliest childhood. He was found to present one of the most repulsive pictures of advanced lupus vulgaris. The entire face was converted into a mass of irregularly wasted, crusted, and cicatrized tissue. The palpebral orifices were almost completely closed; the nose was transformed into a wasted and parchment-like projection from the surrounding crusts; and the mouth had become an irregular slit in the middle of the lower segment of the area of defacing crusts and scars. The accompanying photograph conveys some idea of the hideous transformation which the involved surface had undergone. Father, mother, and two living brothers were in good health. There was no history of tuberculosis or struma in the family record.

CASE XII.—C. H. Came originally from the clinic, Nov. 16, 1883. He was 14 years of age, full-faced, well-nourished, and had suffered from his disease since early life. Father, mother, and two sisters were in good health. No history of struma or tuberculosis in the family record. The left leg was the seat of an extensive patch, reaching from below the patella to near the ankle, made up of cicatricial tissue, ulcers of irregular outline, equally irregular scars, tubercles in progress of degeneration, and crusts. One ulcer had involved the periosteum, and produced thickening of the bone. He gave a distinct history of a succession of developing tubercles, which gradually broke down and ulcerated. He was seen in the course of the following year, having been in the interval under the charge of an excellent physician. By judicious treatment, a great improvement had been wrought in his condition, but the disease was still unchecked.

CASE XIII.—M. H., female, aged 24 years, came with a letter from an eminent surgeon who had charge of her case on Nov. 10, 1884. Her grandparents on both sides lived to advanced years; father living and in good health, aged 48 years; mother, the same, in the 44th year. One brother living, aged 22 years, and in sound health. No deaths; no history of disease or deformity in the family record. The disease began in her tenth year and had always troubled her since. She had been married four years, but had never been pregnant. On the right cheek was a patch of disease which had extended gradually up over the brow of the same side, the whole nearly as large as the palm. It reached well up toward the vertex on the upper part of the brow, which she had covered as well as possible with her hair. The disease had been thoroughly treated by active cauterization, and though still ulcerating at points, was for the most part protected by a thin irregular, and somewhat irritable scar. All her functions were properly performed. She weighed one hundred and thirty pounds; was fairly well nourished; and by the aid of her toilet, concealed the deformity so well that she could have passed for a sound woman in society.

CASE XIV.—A. P., male, came for advice, Nov. 12, 1884, aged 41 years, married seventeen years, one healthy living child, aged 13 years. His wife had lost no child, and had never miscarried. He had suffered from a disease since childhood, which both Hebra and Neumann, in Vienna, had pronounced lupus vulgaris. It had existed upon the face,

and had left that part of the body seamed with irregular cicatrices, corded, ribbed, and in the highest degree deforming. There were still faint irregular lines of ulceration and crusting visible on the right temple and brow of the same side. He gave, however, a history of syphilitic chancre and subsequent signs of general lues, incurred four years after his marriage. When examined, the face of the left leg was seen to be covered with typical syphilitic scars, and pigmented arcolæ. All of these active manifestations of disease yielded to mercurial treatment.

Although syphilitic, I do not hesitate to place this case in the category of lupus, not merely on account of the eminent men who pronounced him, over their own signatures, the subject of that disease, but also because of the indubitable marks of a disorder, not syphilitic, existing long before such infection. His living child was conceived before that occurrence. The patient could give no history of a malady of any kind in his family. He presented a hideous picture of disease, and weighed merely one-hundred and twenty-one pounds; but his health improved markedly.

CASE XV.—C. W. D., female, aged 36 years, married thirteen years, with no children and one miscarriage at the fifth month, reported to have resulted from an accident, sought advice, Jan. 5, 1885. Her father died of consumption at the 37th year; mother living and in good health, aged 60 years; one brother living, the subject of Pott's disease of the spine, and said to be "scrofulous." She reported that when very young she had "lumps in the neck," that there were traces of her present disease, which, however, did not give her much annoyance till her fifteenth year. At that time the right cheek became involved in a dry patch which persisted and finally ulcerated. It had slowly spread during the last few years. When examined, the seat of the disorder named above, was recognized as involved as in an irregular patch of ulceration, crusts, tubercles, and cicatrization. In size it did not exceed the section of a large orange. The health of this patient was poor, and her functions were irregularly performed. Her nutrition, however, was fully up to the average standard. She weighed one hundred and thirty-three pounds.

CASE XVI.—Miss E. B., unmarried female, aged 35 years, applied for advice, Mar. 11, 1885, with a letter from her physician. Her father was said to have died of softening of the brain at 57 years; mother living, aged 60 and in good health, though occasionally affected with rheumatism. Two sisters living, aged respectively 28 and 30 years, both healthy. She weighed one hundred and seventeen pounds, was well nourished, and gave history of good health save as to the cutaneous disorder which had lasted for twenty-five years.

When examined, the left cheek near the lobe of the ear was found to be the seat of an exceedingly irregular ulcerative process, proceeding in a band-like form from below the malar bone in the direction of the tragus. About it on either side were purplish tubercles, sub-epidermic in situation. The inferior segment of the band-like ulcer had healed with production of an irregular and corded scar. Above the ulceration was progressing with purplish edges and a secretion which produced a crust over the part. The floor of this ulcer was softish and hemorrhagic. She had been treated with active cauterization; and by the same procedure, the entire patch was made to cicatrize in the course

of a few months. There was no record of tuberculosis or of struma in her family.

CASE XVII.—The notes of this case, that of a young girl originally brought to the clinic, in February, 1885, are unfortunately defective, the patient having elicited much sympathy by her wretched condition. She was about 15 years of age, an orphan who could give only the most imperfect history of herself or her family, as she had been an object of charity for years. The entire face was converted into a hideous travesty of the human countenance, being wellnigh completely covered with a skin which had undergone cicatricial atrophy to an extent sufficient to disguise and distort each of its organs. Glistening maculations and striations were commingled everywhere with scales and infiltrated plaques. The nose had the characteristic "worn-away" appearance; the eyes were obscured by unsightly, reddened, and swollen lids; the mouth was a contracted, unyielding slit between the glistening-white cheeks stripped of every vestige of normal tissue. On the shoulders were several palm-sized patches of cicatrized ulcers. There was submaxillary and axillary adenopathy. The picture presented was, in brief, that of extreme advance of the disease in a patient long subjected to the worst possible hygienic conditions. The case is to be classed with but two others in this list, illustrating the ravages of lupus vulgaris in uninterrupted evolution in young patients. As respects more particularly the present inquiry, it is unfortunate that the record of her family history could not be obtained.

CASE XVIII.—E. W., female, aged 24 years, unmarried, native of England, sought advice Sept. 10, 1884. She had suffered from her disease for several years, and had been treated for it by cauterization. It was decidedly the slightest manifestation of the pathological process represented in the list of cases here collated. When examined, the right side of the nose was found to be affected with a disease almost limited to the ala. This was covered with a bluish-white, centrally situated cicatricial spot, surrounded by isolated and confluent rather prominent tubercles, some of which were in the course of exfoliation. In one spot above, as though the progress was toward the root of the nose, there was a characteristic, bean-sized, thin-edged ulcer, having a softish, bluish-red floor. The disease was in this instance arrested by active local treatment.

This patient was in a remarkably sound condition of general health. She had a fair color, weighed one hundred and thirty-six pounds, and was even fleshy. She was accompanied by her brother and mother, both of whom appeared unusually vigorous. The father was living and well; one other brother in the same condition. There were two children dead in infancy of infantile disorders.

CASE XIX.—A. P., male, married, farmer by occupation, German by birth, resident of Illinois, was a hospital patient to whom I was called Feb. 25, 1885. He gave an excellent family record, being himself 60 years old, with grown children and grandchildren. There was no history of struma or tuberculosis in either his ancestors or descendants. He was poorly nourished, weighing but one hundred and thirty-five pounds, having at one time weighed one hundred and eighty pounds.

His disease began in early life about the period of puberty, but had been noticeably severe in the present locality only for thirty years. In his childhood, the face and eyes were said to have suffered more.

When examined, he was found to be almost helpless in consequence

of a severe affection primarily of the skin of both hands and arms, reaching well to the upper third of the forearm on each side and involving one elbow. The tissues here, on both flexor and extensor aspects of the arms, the palmar and dorsal surfaces of the hands, and all parts of the fingers, were the seat of extensive ulcers, scars, softening and exfoliating tubercles, deep and superficial atrophy, osteitis and periosteitis, agglutination of tendons, and deformity. Here and there were nut-sized abscesses. Several of the fingers were semi-flexed, thickened, and retracted upon the dorsum of the hand. He was able to apply and remove dressings by the aid only of the forefinger and thumb of each hand. The fourth finger of the right hand was so much enlarged and retracted that it constituted a serious obstacle to the dressing of the parts, and at his urgent solicitation was removed by amputation. Section of the deepest portion of this amputated organ showed after staining characteristic lupus bacilli, and predominantly distinct nests of epithelium, showing that in this part the lupoid growth had been replaced by an epithelioma, a transformation noted in one other of the cases here collated.

CASE XX.—C. P., female, unmarried, aged 16 years, was sent to me from the Illinois Charitable Eye and Ear Infirmary, June 11, 1885. The larger part of the face below the brows, including the nose, cheeks, lips, lower lids, and a small part of the forehead, was the seat of a diffuse infiltration, irregular in contour, here and there marked by adherent crusts covering shallow ulcers, dark reddish tubercles, extensive atrophic cicatrices, and a puffy appearance of the involved area, as though the pathological process had not yet wholly abandoned the field where scarring and wasting marked its progress. The right palpebral orifice was converted into a circular aperture one-half the normal size, resulting from agglutination of the lids; the left was a similar process changed to an obliquely directed slit. There was barely enough vision left to permit of unaided locomotion in the streets. The nose was represented by a thin, parchment-like projection between the shining, scaling, infiltrated, and puffy cheeks. The nostrils exhibited the common peculiarity of a change in the plane of aperture to a slightly inclined vertical.

She stated that she had suffered from the disease for about ten years, which began to attract attention, therefore, about the sixth year of life, but she declared there were ocular changes preceding the facial and strictly cutaneous disorder.

She was a remarkably well developed and vigorous girl, weighing one hundred and one pounds, with no history of any disease whatever save in the face. She had menstruated regularly for one year. Her father's father, father's mother, mother's father, and four brothers and sisters were all living in good health; and gave no history of disease of any kind. One brother had died in his third year of some infantile disorder, while the mother's mother had died in advanced years of a disease reported to be "neuralgia in the head."

Reviewing the significant facts contained in this clinical record, we find them more remarkable for what is lacking than for what is expressed. Of the twenty cases, eleven occurred in women, and nine in men, the proportion being nearly that stated by other observers. The average age at date of examination was somewhat over thirty years, this period being

unusually advanced on account of the inclusion of the cases of two aged patients who had suffered from the disease for nearly a lifetime. The age at which the earliest manifestations of lupus were noted is set down in but a few instances, and the inferences on this point are thus without value. The reason for this is that the knowledge had by patients of the disease, as it appeared in childhood, is often of a traditional character.

As to the regions affected, in seven cases the cheek was involved; in four, the greater part of the face; in two, the nose; and in one each, the ear, the belly, the chin and buttock, the lip and nose, the forearms and hands, and the leg.

More significant is the family report represented by these cases. Of the relatives of the subjects of the disease, there were living and in sound health seven grandparents, fifteen parents, twenty-six brothers and sisters, thirteen children, and four grandchildren. Of the dead, the record is singularly defective in point of association with eaehectic disorders. One parent only is stated to have died of phthisis; one was drowned; one reported as suffering from "softening of the brain." One grandparent is reported dead of "neuralgia." One brother was said to be suffering from Pott's disease of the spine. One child died of diphtheria; one of cholera infantum; others of the disorders of infancy, which could not be described. In two cases there is no family record of any kind.

Of the two patients referred to above, as attaining advanced age, it may be remarked that each eventually suffered from an epithelioma originating in the lupus tissue. It seems probable that when lupus vulgaris persists to the fiftieth or sixtieth year of life, it either undergoes a species of involution, the disease no longer extending as in the earlier ages, or it undergoes an epitheliomatous transformation. A very full bibliography of papers touching upon this point is appended to an interesting monograph on *Lupus Karcinomi* by Dr. Jos. Schütz.¹

The description of the appearance of an epithelioma resulting from such lupus transformation in the cheek, given very graphically by Hebra, might almost serve for a portrait of one of the cases here collated.

One of the patients described above was without question the victim of a syphilis incurred years after he had been treated by two eminent German dermatologists for lupus of the face.

If the statistics of the dermatological clinic, which I have held weekly for years in the city of Chicago, be compared with the facts and figures described above, I am quite confident that the conclusions will be very nearly those just stated. Special attention has been given to this point in the examination of every lupus patient, the questioning having been conducted in public, in the presence of many students and practitioners.

¹ *Monatsschrift f. prakt. Derm.*, Bd. iv., No. 3, März, 1885, p. 74.

With every effort to throw light upon this question, no patient has ever been presented at this clinic, suffering from coincidence of lupus vulgaris and unmistakable tuberculosis of the lungs. Numbers of the subjects of the disease last named are constantly applying to the proper department of the dispensary for relief, and any instances of lupus vulgaris among them would be assigned at once to the dermatological clinic. Further, no clear record has been given by any of these patients examined in public of the existence of tuberculosis or struma in any branch of the family.

Yet such records in other cases are constantly accumulating. For example, a young girl lately applied for relief of an eruption that was recognized as a dermatitis medicamentosa induced by arsenic given internally for relief of some systemic trouble. It was noticed that she limped and wore a brace over the left ankle. When questioned, she reported that that joint had been diseased for many years; that her father and four other members of her family had died of phthisis, and that a living sister was suffering from the same disease.

(To be continued.)

AMERICAN DERMATOLOGICAL ASSOCIATION.

NINTH ANNUAL MEETING, HELD AUGUST 26, 27 AND 28, 1885.

Official Report of the Proceedings by the Secretary.

(Concluded from p. 318.)

DR. TILDEN then read a paper on

“MYCOSIS FONGOÏDE.”

It described the case of a man, twenty-eight years of age, who, having been in good health until his twenty-fifth year, was then, for the first time, aware of the appearance upon his elbows of several small red and desquamating spots which were attended with pruritus, affecting principally the outer sides of the arms. There were no further manifestations of cutaneous disease for several months, at the end of which time there appeared irregularly distributed upon the face, abdomen, and arms, erythematous spots and patches of various sizes and individually of a fugitive nature, accompanied by pruritus, which was the only subjective symptom of which the patient complained. According to his statement, these cutaneous lesions always retained their dry and scaly character, and were never accompanied by anything like the formation of vesicles.

With temporary variations in severity, these changes in the skin con-

tinued for about a year and a half, attended with pruritus, but unaccompanied by any change in the previous good health of the patient. At the end of this time, and for the first time, there appeared several small, red cutaneous nodules upon the left cheek and throat. Some of these nodules spontaneously disappeared, and no others showed themselves, when there appeared upon the right thigh a small papule which slowly increased in size until it formed a tumor the size of an orange, the upper surface of which was deprived of epidermis. From the pathological tissue thus exposed there exuded a thin, reddish fluid, which dried to a thin crust. The appearance of this papule was followed during the succeeding year of the disease by the development in many parts of the body, more particularly the axillæ, groins, neck, and scalp, of similar papules, many of which had developed into tubercles the size of a filbert, and several into tumors as large or larger than a hen's egg. These lesions were at first of moderately firm consistence, and covered with smooth, pale-red epidermis, being circumscribed and rounded elevations. Under conditions of fusion and coalition of these nodules, were formed irregularly outlined, uneven, and sometimes fissured, infiltrated patches of a darker, more brownish, or bluish-red color than the original and isolated lesions, and covered for the most part with epidermis, being only here and there excoriated and oozing. Several of the larger tumors reached a stage in their evolution at which began a sluggish involution or retrograde change, manifested by the disappearance of the epidermis which covered them, thus representing the typical moist fungous excrescences of mycosis fungoïde.

In spite of this superficial erosion, the tumors affected by it preserved their size and shape for a long time. The excoriated tumors were firm in consistence, but several, which were still covered with epidermis, more particularly those upon the head, were so soft as to suggest fluid or semi-fluid contents. There were in none of these lesions any evidence of the formation of pus, or any deeply destructive ulceration. There was severe and general pruritus, but the general health of the patient was fair, the chief subjective symptoms, besides the itching, being a feeling of weakness and shortness of breath upon exertion. There was evident anæmia, and the heart presented a systolic murmur, but physical examination failed to detect anything out of the way, except indolent and painless enlargement of many of the accessible lymphatic glands.

The patient remained under observation for three months, during which time there took place development of fresh papules from previously existing erythematous spots. The last time he was seen, one of the largest tumors had entirely disappeared, and its original site was covered with epidermis, while the largest tumor of all had diminished in size by nearly one-third, without the manifestation of any quickly destructive

ulceration. During the last four months the patient was not seen, but his death about three years and eight months after the beginning of the disease became indirectly known to Dr. Tilden. Two of the small nodules were excised and given to Dr. Gannett, pathologist to the Boston City Hospital, for examination, whose report showed them to consist of the new formation of cytogenous or lymphoid tissue in the corium, characterized by the presence of a fine network of connective-tissue fibres, anastomosing to form spaces of nearly circular shape, which contained round cells resembling leucocytes in appearance, the presence of which network in the new growths of mycosis fungoïde was originally described by Ranvier.

DISCUSSION.

DR. WHITE stated that he saw the patient towards the end of his life, and had observed the same wonderful changes as had been described in the growths, many of them gradually disappearing. During the last four or five months of his life, the patient had been given arsenic, under the supposition that the disease might be sarcoma. (Arsenic had been found to render great service in two cases of this disease; one reported by Köbner, and one which occurred in Boston.) Dr. Tilden's patient improved decidedly under the use of this drug. His death was due to a sudden attack of diarrhoea. He (Dr. W.) had no opinion to offer as to the nature of the disease. He saw no reason why multiple sarcoma could not terminate in this affection. No autopsy was made in the case.

DR. ROHÉ had seen a case similar to the one described. He then thought it sarcoma.

DR. FOX had seen one or two similar cases in New York. If he had one to treat, he would try the effects of chaulmoogra oil.

DR. HARDAWAY alluded to a case of pigmented sarcoma which he had reported four or five years ago. The man was still alive.

DR. WHITE said that he had seen a case which had been regarded as one of "remarkable syphilis," and had found it to be an instance of the affection under discussion.

DR. DUHRING spoke of a case of the disease which he had described. In it lesions of the wall of the bladder were found after death. At present he would consider the disease as closely allied to sarcoma. He thought that the differences between well-recognized forms of sarcoma were as great as between sarcoma and mycosis fungoïde.

DR. HEITZMAN said that the histologist who had examined the specimen had described a myxo-sarcoma, and he was unable to understand how he had reached the conclusion that the disease was not a sarcoma. The clinical history, and the description given of the case, fitted myxo-sarcoma exactly, and he saw no valid reason for the use of the term "mycosis." He thought it a plain case of sarcoma.

DR. SHERWELL spoke of a case of melano-sarcoma, where there were many pedunculated and flattened tumors on the body and leg. The patient was vigorously treated with arsenic and mercurials, and is now almost free from the disease.

DR. HARDAWAY asked Dr. Heitzman if microscopical differences

would account for differences in the clinical course of the various sarcomata?

DR. HEITZMAN said that since Billroth had described alveolar sarcoma, it had been recognized as a less malignant affection than myxoid or fibro-sarcoma. Billroth had, it was true, afterwards withdrawn his statement that it was a form of sarcoma and had called it cancer, but he (H.) was still of the opinion that it was a variety of sarcoma.

DR. TILDEN said that patients with this disease generally die of exhaustion, often with diarrhoea, but presenting no internal lesions to account for death. He had chosen the name mycosis fungoides because he knew no better one. He was confident that it was neither sarcoma nor lymphoma. Its clinical course was not at all like that of ordinary multiple sarcoma, as described in writings on the subject; particularly as regarded the rapid spontaneous involution of many of the lesions.

DR. WHITE said that sarcomata might also disappear under arsenic by hundreds, and, as he had seen in one case, in which as many as two hundred tumors thus disappeared, stay away two years.

After studying the microscopical specimens exhibited by Dr. Tilden, DR. HEITZMAN pronounced the case to be, not one of myxo-sarcoma, as he had supposed it to be, but of lympho-sarcoma.

DR. DENSLOW then read a paper on

THE TREATMENT OF ACNE BY THE USE OF SOUNDS IN THE URETHRA.

He prefaced his remarks by a brief review of the cases of contracted meatus reported by Dr. Otis. He then gave an account of a number of cases coming under his observation, in which there were reflex conditions associated with such conditions of the urethra as contracted meatus, stricture, and excessive sensitiveness of the prostatic urethra. In these cases removal of the urethral trouble produced an alleviation or cure of the affection to which attention had been directed. He also reported four cases in which the same treatment was followed by marked improvement or cure of the skin disease (acne).

DISCUSSION.

DR. HYDE desired to call attention to a fact bearing upon the subject discussed in the paper, viz., that many patients with urethral troubles were in the habit of taking internal remedies without the knowledge of the physician, which might, he thought, often excite acne medicamentosa, or they might be taking drugs secretly for sexual hypochondriasis, under the belief that they had blood-poisoning. He would ask Dr. Denslow, in treating cases of acne with sounds in the future, to ascertain how many of the patients had been taking drugs, and how many stopped using them at about the time the acne improved.

DR. DENSLOW said that in none of the patients whose cases he reported was the acne due to drugs, and none of them were in the habit of masturbation. He had no theory of the etiology of acne to advance, but had in his paper simply reported a small number of facts which he had observed since January.

Third Day.

DR. HEITZMAN made some

REMARKS ON ELECTROLYSIS AND OTHER PRACTICAL TOPICS.

He recommended for the electrolytic destruction of the papillæ of hairs, in cases of superfluous hairs on ladies' faces, the Leclanché battery, consisting of six large cells (each over 12" in height) united to one circuit. The advantages of this battery are: it is painless, even the most sensitive person can stand it without inconvenience; the reaction following the introduction of the needle is slight, passing away in a few hours; no pustule and no scar would follow; it is in steady action for at least half a year. Perhaps the failures to destroy the roots of hairs occur more frequently than with the more powerful chromic acid battery. In some cases it happens that a number of downy hairs, after the removal of large hairs, grow up to a large size very quickly, which, perhaps, is due to the carrying of cast-off nutritive material to the fine hairs.

He exhibited a needle-holder, manufactured by Leiter, of Vienna, offering the advantage that the depth to which the needle is introduced could be accurately measured.

Stronger and painful currents had in his hands proved highly satisfactory for the destruction of dilated blood-vessels in the face, the last remnants of rosacea. Less favorable results were obtained in the destruction of flat angioma-spots, so-called port-wine marks. Some cases could be reduced in the tint of their color, others made to disappear, but sometimes after a few months all improvement disappears, and the angioma looks as bad as ever. Trials with the alcoholic solution of sodium æthyl proved that this caustic is in no way superior to nitric acid, and that it is prone to produce scars if brought to bear upon the skin for any length of time, the same as is nitric acid. He described a case of a pale spot on the left cheek of a lady over forty, which was two inches in diameter, dark purple-red and sharply circumscribed, evidently caused by a vasomotor (sympathetic) paralysis. In this case even strong electrolytic currents proved to be of no avail.

The speaker then summed up the results of two hundred cases of falling of the hairs caused by seborrhœa, where he applied the tar-pomatum recommended by him in 1876 (10 to 20 p. c. ol. rusci crnd. in vaseline and paraffin, the smell of the tar being nearly destroyed by means of fragrant oils). 12 p. c. of these cases proved to be failures: in a double percentage, the improvement was but temporary; in a limited number the favorable result was lasting. He considers this pomatum a valuable remedy, always to be tried in suitable cases, alternately with sulphur and white precipitate ointments.

He recommended for the removal of freckles an ointment, the formula

of which was given him by Prof. Wertheim in Vienna. The ointment is hydrarg. ammon. muriat., grams 3.75; magister. bismuth, 3.5; unguent. glycerini, 30.; to be applied only every other night.

DISCUSSION.

DR. WHITE said that he thought the fact that Dr. Heitzman obtained no better results from electrolysis was owing to the circumstance that his current was not strong enough, not causing pain. He himself did not anticipate that more than one hair in ten would return; on the upper lip, not more than one in twenty; whereas Dr. H. expected three or four in the same number to grow again. He himself always produced some pain in operating. He was accustomed to use a chloride of silver battery, which had the advantage of requiring to be filled only once a year. It contained twelve cells, of which he used from six to ten, rarely the whole number. He was accustomed to tell patients that on the chin and neck only one hair in four could be permanently destroyed. He thought the needle-holder exhibited by Dr. Heitzman too short by half, and preferred one the length and size of an unshortened lead-pencil. He did not consider the shoulder or guard necessary, believing that the educated touch was sufficient to regulate the depth of penetration. He used on all parts of the face, except the upper lip, the common steel broach of very small size. Such a needle could be easily bent, and was almost indestructible. He had used one for thirteen months one hour daily; on the upper lip he preferred to use the irido-platinum needle, which is made extremely fine. He thought the cosmetic effect was in proportion to the smallness of the needle used.

As regarded the treatment of seborrhœa of the scalp, he always gave a favorable prognosis in the case of females, an unfavorable one to males. He, too, liked the effects of tar, but thought the odor and nastiness of the drug objectionable. He now used salicylic acid and sulphur, as recommended by Unna, with very good results.

DR. HYDE, alluding to the statement of Dr. Heitzman, that the nutritive material destined for the large thick hairs was diverted to the downy hairs after the removal of the former, said that in the case of a patient with long black hairs on the chin, if the operation is done, the hairs return and the operation is repeated. Thus an excessive hyperæmia is excited, leading often to urticaria, papulation, or pustulation, and conditions favorable to the growth of hairs. The down grew into coarse dark hairs.

He thought that great injustice had been done the American operation in the last volume of Ziemssen's *Cyclopædia*, in which it was stated that fifty per cent of the hairs returned after removal.

He indorsed what Dr. White had said about the uselessness of a guard on the needle-holder, and preferred the steel broach or irido-platinum needle to anything he had ever seen for the removal of hairs. He had used the rectified oleum rosei and thought highly of it, and was surprised to learn that Dr. Heitzman thought so little of it.

DR. ROHÉ used the McIntosh, a bichromate battery with small cells. He rarely used more than ten or twelve. He had found that the Leclanché cells soon wore out, and being open circuit cells they had to stand a long time to recover.

DR. FOX said that any battery producing a good electro-motive force was good for electrolysis, and that keeping the connections bright and clean was far more important than the choice of any particular battery. In the treatment of *nævi*, he was in the habit of applying nitric acid in the form of small dots a quarter to a half inch apart. He also liked the effect of the passage of a galvano-cautery instrument quickly over the skin. This caused contraction of the vessels and left no scars.

He thought that, in electrolysis for the removal of hairs, if the needle were carefully inserted and no traction made, the hair would not return. In his experience about one per cent returned. He thought that in some exceptional cases there was a tendency to the constant growth of downy hairs. In other cases, where this tendency is no longer present, the result of treatment is better. He did not accept Dr. Heitzman's theory that the extra nutrition left after removal of large hairs went to the downy ones, nor did he think that the hyperæmia produced by the operation stimulated the growth of the remaining hairs.

He thought that the general results of the operation were good, and spoke of one case in which he removed eight thousand hairs, the face being now practically free from hair and had been for three years. The marks left by the operation were exceedingly slight. The choice of holder and needle was a matter solely of personal preference. He was surprised at the success obtained by Dr. Heitzman from the use of the ointment whose formula he had given, and would expect them to reappear after a time.

DR. ROBINSON had used a similar salve for years, and had found that it had a temporary good effect, making the skin clear and rendering the pigment less visible. He thought that chronic hyperæmia did increase the growth of hair, as shown by the fact that over fractures, and sometimes after eczema, the hairs grow more abundantly than on other parts. He used electrolysis only in those cases where there were a few large hairs, not those in which they were abundant and of all kinds.

DR. WHITE thought that after the operation the lanugo hairs simply grew on but were not stimulated by the operation, simply becoming more prominent because the large hairs had been removed.

DR. HARDAWAY said that he had been doing this operation for the past eight or ten years and thought very highly of it. He was glad to hear that Dr. Heitzman's views of it had changed, and that he now admitted that it was a true electrolysis and no galvano-cautery.

He liked to use a heavy holder, so that the needle would pass in by its own weight, thus avoiding perforation of the follicle-wall. The irido-platinum needle, which was first suggested by Piffard, had the advantage of bending like a bougie and following the course of the canal. He used the MacIntosh battery, and found it a very good one. He thought that much less scarring would follow the operation if the needle were coated up to a certain point so as to make the destruction subcutaneous.

He often told patients that the downy hairs would become visible after the large ones were removed. He knew that the operation was often a complete and radical success, the hairs never returning. His first case was that of a bearded woman, whom he treated about twelve years ago. She is now practically relieved from her disfigurement, although many scars were present he would admit.

He thought a point of great importance was to use hot water three or

four times a day after the operation, and another was to make the operations far apart, at least once a week, to allow the skin time to recuperate. He had tried cocaine to relieve the pain, but had never seen it do any good in this way. He thought it was important to leave the hairs in situ until the electrolytic action was complete, and then to pull very cautiously. The expert touch would of course tell when the follicle was reached, but he had often noticed that the sebum would froth out before the connection was made, showing that the follicle was entered.

He regarded the use of electrolysis as a valuable means of getting rid of freckles, particularly the large dark ones, dotting them with a stiff needle. The best drug for their cure was in his opinion sulphur.

DR. ROHÉ had noticed the frothing when the needle entered the follicle, and had found the reason to be an accidental defective connection prematurely made.

DR. HEITZMAN said that in his experience one hair in four will return on the upper lip and neck, and one in ten on the chin. He did not think that personal skill had much to do with the success or failure of the operation. Hairs were often spiral or corkscrew-like, and the papillæ could not of course be reached.

He thought there was only one test for good oleum rusci crudum, and that was to mix the specimen with three parts of alcohol, put it on the finger, and if it dried in a few minutes it was good. The rectified oil dries more slowly and leaves a black mark. He had found that the remedy only did good in baldness, when seborrhœa was the cause of the trouble.

DR. TAYLOR then read a paper

ON SYPHILITIC REINFECTION.

He first referred to the literature of the subject, and gave a brief review of the authentic cases on record, giving the names of the reporters. The number of cases previously reported is between thirty and forty. To these he added the histories of three more. A fourth case has been observed by him, but, as the complete history was not prepared, it was not given.

DISCUSSION.

DR. HYDE thanked Dr. Taylor for so valuable a contribution to our knowledge of this rare occurrence. He himself had seen only two cases of reinfection, many others which at first were thought to be of this nature proving to be simply relapsing indurations.

DR. STELWAGON then read a paper entitled:

“OBSERVATIONS ON THE OLEATES IN SKIN DISEASE.”

In it he regretted the lack of reliable observation concerning the action of the oleate preparations. His personal experience, somewhat extended, had placed in question their therapeutical importance. The oleate of mercury, oleate of lead, oleate of zinc, and oleate of bismuth in

his judgment were the only oleates that had proven of service. The oleate of mercury in inunction treatment of syphilis is not comparable to the blue ointment; in fact, the ready absorbability of the former mercurial is questioned, the writer's clinical observation in this respect being in accord with the experiments made by Dr. Brubaker, of Philadelphia, to determine the same question. The oleate of mercury, in the form of a twenty-five per cent ointment, is especially valuable in the treatment of ringworm of the scalp, and the same, or a somewhat weaker ointment equally efficacious in tinea sycosis. He had found oleate of copper of very little value. The oleate of lead melted with an equal part or more, dependent upon the season, of lard, forms a soothing and astringent ointment, an efficient substitute for diachylon ointment. Oleate of zinc, in ointment, compared to oxide of zinc, is more astringent and stimulating, but more apt to disagree as a dusting powder, the conclusion reached was that it is impracticable, as in the presence of heat and moisture (that of the skin sufficient) it becomes sticky. The oleate of bismuth, with lard, or alone, forms a soothing ointment.

In view of the difficulty of securing good preparations, the disagreeable oleic acid odor, the costliness, the frequency of unlooked-for irritating effects and other disadvantages, the writer concluded that the oleate of mercury is the only preparation which promises to hold a permanent value, and even that recedes from its importance of a few years ago.

In regard to the chemistry and preparation of the various oleates, both as to their manufacture by the direct combination of the acid with the base and by double decomposition, almost, if not entirely, as much can be found in the English translation of Gmelin's "Handbook of Chemistry," published in 1866, as in the writings of the past several years.

DISCUSSION.

DR. TILDEN thought the oleates of but little value, and that the oleate of mercury was not so good as blue ointment.

DR. WIGGLESWORTH believed that the only value of the oleate of mercury was as a parasiticide.

DR. DUHRING coincided with the conclusions of the reader of the paper. A few years ago, he was treating forty or fifty cases of ringworm, and used large quantities of a pure preparation of the oleate of copper, gave it a faithful test, but found it had no influence on the disease, which continued to spread. There were no cases of recent ringworm among the number. The drug was also very unpleasant to apply to the skin.

DR. HEITZMAN had found that the oleate of copper did good only in the acute stage of ringworm.

DR. FOX said that in his experience vaseline was much more readily absorbed by the skin than oleates or animal oils. Vaseline he thought the most soothing of all applications, and he had made careful observations.

DR. SHERWELL had not used oleate of copper. He had used the five-per-cent oleate of mereury, which was a very unstable compound. This he had found to do good in even a very weak mixture. As regarded vaseline, he detested it, and thought it almost an irritant. He much preferred cold cream for soothing purposes.

DR. TAYLOR also regarded vaseline as an irritant. The unperfumed white vaseline was less so than the brown, but eosmoline he thought better than either.

DR. WHITE had tried oleate of copper several times as a parasiticide, but without success.

DR. HARDAWAY had used oleates, but had now discarded them entirely. He had had some success with oleate of copper as a parasiticide.

DR. DENSLOW then read a paper on

A CASE OF SYPHILITIC APHASIA AND PARAPLEGIA FOLLOWED BY DEATH,
WITH AN ACCOUNT OF THE AUTOPSY.

About two months before, the patient, a middle-aged man, was first seen, he was attacked by a severe headache, much worse at night. He was found to have alopecia, and a papular eruption most marked about the face and scalp. He had had a sore on the penis a few months before. He was then given iodide of potassium in increasing doses, up to half an ounce daily, and eroton chloral. At the end of two weeks he was free from pain. The pain returned two weeks later, and he was again ordered large doses of iodide. By mistake he took drachm doses every two hours, which upset his stomach, but failed to relieve the pain.

When first seen by Dr. Denslow, he was unable to speak or to comprehend questions, and was paraplegic. He sank rapidly and soon died.

On autopsy, the dura mater along the superior longitudinal sinus was found to be thickened and adherent to the pia mater. On the external surface of the pia there were numerous small gummata or cheesy-like masses about the size of millet seeds; these were situated mostly along the right border of the superior longitudinal sinus, extending down to the upper extremity of the fissure of Sylvius. Both the dura and the pia mater showed signs of simple acute inflammatory changes in the regions covered by the masses. The ventricles and interior of the brain showed no pathological changes.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

156TH REGULAR MEETING, SEPTEMBER 22D, 1885.

DR. W. T. ALEXANDER, *President, in the Chair.*

DR. FOX presented a case of

LICHEN RUBER.

W. L., 2 years and 9 months old. A scaly eruption made its appearance on the knees and elbows, a few months after birth, and has remained there ever since. There has been an eruption around the umbilicus and on the neck, but it has disappeared from these locations.

Now a greater part of the skin from the hips to the ankles is covered with a large infiltrated patch, yellowish-red in color. The surface is dry and harsh, and presents a mealy condition, but there are no scales that can be removed. Toward the ankles the patches have a scalloped border, with a few outlying guttate spots. On the healthy skin above the ankle the follicles present the appearance of minute black points, which the mother says are the precursors of the eruption. There is an eruption on the arms similar to that on the lower extremities, the extensor surfaces being most affected. There are small pin-head follicular elevations of a dull color, many being surmounted by a fine scale. The scalp is dry and harsh, but there is a good growth of flaxen hair. The bends of the elbows and popliteal spaces are free from eruption. The skin of the whole surface is somewhat thickened and slightly reddened.

In showing the case, Dr. Fox said that it presented many of the features of the case of lichen ruber occurring in a French boy, and which was shown at a meeting of the Society four or five years ago. In that case, there was a peculiar wrinkled appearance of the skin, and many papules covered with small scales. Both cases presented many of the appearances seen in the disease described by Jonathan Hutchinson as lichen psoriasis.

DR. BULKLEY said that he saw the lesion soon after it made its appearance, and because of the dryness of the skin, the scaliness, and also because it occurred shortly after birth, he called it *ichthyosis neonatorum*.

DR. ALEXANDER asked what treatment had been employed.

DR. FOX said that he had only seen the case recently, and continued the former treatment, viz., inunction of oil.

DR. ROBINSON presented a case of

XANTHOMA OF THE ELBOWS.

The patient, a woman about 40 years old, had a large patch of xanthoma on both elbows, and nowhere else on the body. In addition, there was some obstruction of the sweat ducts of the face. Patient never had jaundice. She suffered considerably from catarrhal dyspepsia.

DR. PIFFARD said that it was the first time that he had seen xanthoma on the body only, and not on the face as well.

DR. BULKLEY said that it was undoubtedly rare to find xanthoma on the body only, but he had seen quite a number of such cases.

DR. ROBINSON said that he also wished to call attention to the obstruction of the sweat ducts on the face. Many of the single lesions last two or three weeks, or even months. He would classify the latter lesion under the head of sudamina.

DR. FOX showed a case of

FOLLICULAR ECZEMA.

The patient a man, 35 years of age, has had an eczema off and on for the past three or four years. The present eruption appeared a year ago, following a severe eczema of the genitals and thighs.

Now the lesions are situated on the outer aspect of the lower extremities, involving nearly all the legs. The lesions are papulo-pustular and mainly confluent, shading off into discrete papules and pustules. Around the ulnar side of the wrist are a few small papules. The follicles are involved, and where the eruption has remained longest there are numerous horny masses, each surrounded by a brownish-red areola. These horny projections appear at a distance like minute scales; they can be dug out of the follicular openings, slight hemorrhage resulting. On passing the hand over the surface, a shotty feeling is perceived; a few deep-seated lumps are to be felt, similar to an acne induration. The pustules are chiefly small, flattened, and projecting above the surface, almost every one being pierced by a fine hair.

DR. KEYES said that he had seen a similar case occurring in a stoker in Paris. The case just shown presented many of the appearances of an acne.

DR. ROBINSON said that he had been of late studying many cases like the one presented. He believed it to be a peri-folliculitis, or a follicular eczema. The lesions are generally diffuse, and found especially on the extremities. In nearly all the cases there is some intestinal disorder present.

DR. BRONSON agreed in the main with Dr. Robinson; it seemed to him to be analogous to eczema, but there was only a slight difference between this case and a sycosis. He would call the lesion follicular eczema.

DR. BULKLEY regarded it as a deep-seated impetiginous eczema. He would give anti-syphilitic treatment, as he had often obtained benefit from its use in chronic cases of eczema.

DR. PIFFARD thought the case to be essentially an eczema running down into the follicles. He would epilate and give large doses of sulphide of calcium.

DR. MORROW then presented a case of

PSORIASIS PALMARIS,

in a man about 25 years old. The patient had a guttate psoriasis scattered over the body, and there were numerous small and characteristic lesions in both palms. He showed the case because some of the members had questioned whether psoriasis ever occurred on the palms.

DR. KEYES believed the case to be one of psoriasis, and that there were no evidences of syphilis.

DR. BRONSON could see no signs of syphilis. He said that in the last edition of Neumann's plates two or three cases of psoriasis palmaris were portrayed, similar to this one.

DR. BULKLEY said he had never seen a psoriasis of the palms in which there were so many minute points of eruption as in this case; to his mind there were evidences of syphilis.

DR. MORROW said that he had a patient in Charity Hospital, in whom a psoriasis had developed twice under his observation. There were numerous minute psoriatic lesions on the palms presenting appearances similar if not identical with the case shown.

Selections.

THE PATHOGENESIS OF CERTAIN AFFECTIONS OF THE SKIN.¹

"Diseased nature oftentimes breaks forth in strange eruptions."

It is well known that the introduction of various drugs into the stomach is sometimes followed by the appearance of a cutaneous eruption, and that the connection between them is one of cause and effect. One of the most common of the so-called medicinal eruptions, consisting of the acneform, pustular, and sometimes furuncular lesions due to the administration of the iodide or bromide of potassium, has been attributed to direct irritation of the glands of the skin because of the attempted cutaneous elimination of the drug from the system, and the detection of iodine and bromine in the pus obtained from the cutaneous lesions gives to this idea apparent support. The histological character of such lesions, however, according to Duckworth, does not indicate that the cutaneous glands are primarily involved, while more recent microscopic investigation shows that, although lesions caused by the internal use of iodine and bromine preparations may originate in dilatation and cellular infiltration of the capillary network which surrounds the sebaceous glands, the same process also affects blood-vessels which have nothing to do with the glandular apparatus of the skin, and may develop to such an extent that the consequent lesions represent a pustular dermatitis. The attribute of an eliminative pathogenesis, therefore, cannot be given to this variety of eruption until more evidence in its favor is forthcoming, although the occasional inception of the process in the neighborhood of the cutaneous glands is suggestive of the ancient maxim, *ubi irritatio, ibi affluxus*.

Other forms of cutaneous lesions may also arise from the internal use of iodine and bromine compounds, and offer for consideration a large class of medicinal eruptions which differ in appearance from those just mentioned, and are independent of the physiological or therapeutic action of the drug to which they are due. They may be caused by many different drugs, and present a variety of forms, the most common and well recognized of which are as follows:

(1) Simple and evanescent erythematous patches, unattended by constitutional disturbance, and not apt to be followed by desquamation, which have been observed after the use of quinine, antipyrine, copaiba, iodide and bromide of potassium, cubebs, and benzoate of soda.

(2) Papular erythematous lesions, attended with exudation into the cutaneous tissues, and resembling in some cases measles, in others the various forms of erythema multiforme, have been produced by the ingestion of quinine, antipyrine, copaiba, and iodide of potassium.

(3) A diffuse form of erythematous dermatitis, not unfrequently accompanied by constitutional derangement, generally followed by desquamation, and often closely simulating the rash of scarlet fever, has occurred in consequence of the administration of salicylic acid, quinine, opium, morphia, and iodide of potassium.

(4) An urticarial eruption, consisting of wheals, is the most common of the medicinal eruptions, is apt to be combined with other forms and attended with constitutional disturbance, and has been described as following the use of co-

¹ Read before the Massachusetts Medical Society, June 9, 1885, and recommended for publication by the Society.

paiba, quinine, salicylic acid, antipyrine, iodide and bromide of potassium, opium, morphia, chloral hydrate, and arsenic.

(5) Purpuric eruptions, or circumscribed exudation of blood into the dermal tissues, sometimes accompanied by hæmorrhages from the mucous membranes, are reported as having occurred from the use of quinine, salicylic acid, iodide of potassium, and chloral hydrate.

Much less common than the above are:

(1) Bullous or pemphigoid eruptions. Such cutaneous lesions occurring after the use of iodide of potassium are rare, but well recognized, and isolated instances of the same are recorded as taking place after the use of bromide of potassium and copaiba.

(2) Vesicular eruptions resembling eczema have been described as following the use of various drugs, but they are exceptional, and the details with regard to them are meagre.

Attacks of typical herpes zoster are described by Hutchinson and others as occurring during the administration of arsenic, but it is a question whether such eruptions are not to be regarded as coincidences rather than consequent phenomena.

(3) A scaly eruption, resembling psoriasis, is mentioned by Gower as appearing, in three cases, during the administration of borax.

The drugs which are most apt to excite cutaneous eruptions, when given internally, are quinine, salicylic acid, copaiba, preparations of iodine and bromine, and it is worthy of notice that the new remedy, antipyrine, is especially prone to give rise to cutaneous manifestations, being followed by them, according to one observer, in ten per cent of the cases in which it is used. Contrary to the opinion of Besnier, who supposed them to be due to reflex nervous disturbance, caused by gastric irritation, these eruptions may ensue whether the drugs which excite them are introduced into the system by way of the stomach, by absorption through the mucous membrane of the rectum, by subcutaneous injection, or by contact with a wounded surface. They make their appearance shortly after the absorption of the drug has taken place, are acute, and run a rapid course in comparison with the pustular dermatitis due to iodine and bromine; are not unfrequently ushered in by a chill and accompanied by vomiting, headache, and fever, offering a temporary but striking likeness to the acute exanthemata; are aggravated by the continuance or increase in the dose of the drug which causes them, and disappear upon its disuse. In some cases, however, the system seems to acquire a tolerance of the drug, and the cutaneous and other symptoms disappear, notwithstanding its continued administration.

The pathogenesis of the medicinal eruptions is of importance as throwing light upon other and analogous pathological processes, but its nature is too complicated, and our knowledge too limited, to permit any such syllogistic and sweeping assertion of its neurotic character as has recently been made in the *JOURNAL OF CUTANEOUS AND VENEREAL DISEASES*.

With regard to the pustular lesions so often caused by the use of iodine and bromine compounds, the evidence, taken for what it is worth, indicates that the changes in the skin are due to direct irritation of its tissues, on account of the presence therein of iodine and bromine, two very irritating substances. The deposition of finely divided metallic silver in the corium, and consequent discoloration of the skin, which sometimes follows the long-continued administration of nitrate of silver, demonstrates the possibility of the accumulation of a drug in the cutaneous tissues after its internal use, while the typical inflammatory

and suppurative character of the lesions in question suggests reaction to direct irritation, and the detection of iodine and bromine furnishes the material for such irritation. In most cases these inflammatory changes in the skin do not appear until the drug has been taken for some time, and personal idiosyncrasy does not seem to play so prominent a part in their causation as in that of the other varieties of medicinal eruptions, there not being manifest the same general condition of vascular irritability which is often connected with the latter. The production of the pustular dermatitis caused by iodine and bromine seems rather to be a question of the amount of the drug received into the system compared with the individual's capacity for its elimination by the proper channels; an interesting fact in this connection being the observation that in cases of Bright's disease, where the eliminating powers of the kidneys are crippled, this form of eruption takes place sooner and after smaller doses of the drug than usual.

As to the other varieties of medicinal eruptions, although they differ widely from each other in appearance, many of them are due to what looks like disturbance of the vaso-motor system, and belong to the so-called angio-neurotic lesions of the skin, the type of which is furnished by the wheal of urticaria; and both Pellizzari and Erb call particular attention to the general and increased irritability of the cutaneous vascular system which is present in these cases, a condition of things revealed by the ready formation of the so-called "taches cérébrales," first pointed out by Trousseau in connection with meningitis. Pathologically speaking, angio-neurotic lesions of the skin consist in various and varying degrees of dilatation of its capillaries, attended with more or less exudation of serum and wandering cells, separately or in combination, and such processes manifest themselves clinically by erythema of various types and urticarial eruptions. With regard to the bullous eruptions due to iodide of potassium, it may be stated that an angio-neurotic lesion of the skin, such as erythema or urticaria, may, by sudden and excessive exudation of serum, which causes the elevation of the epidermis *en masse*, develop into a bullous eruption, and it is a question as to how many of these pemphigoid lesions are of this nature. For the production of the hæmorrhages into the cutaneous tissues which take place in the purpuric eruptions, there is apparently necessary some change in the capillary walls themselves, for the red blood-globule does not possess the power of amoeboid movement which enables the white blood-cell to migrate through the protoplasm of which the walls of the capillaries are composed. This process is generally independent of any angio-neurotic manifestations, although it may be combined with them, and thus give rise to a hemorrhagic variety of such lesions. In what manner the presence of a drug, or some modification of the same, in the system causes such pathological changes in the skin: whether by disturbance of the central or peripheral nervous system, by irritation of the capillaries themselves, or by a combination of the two processes is a matter of speculation which is premature in proportion to the extent of our ignorance; but the truistic assertion may be made, that the entrance in some way into the circulatory system of the drug which causes them is requisite for the production of these eruptions. In any individual instance, the factor which seems to determine the morphology of the eruption is personal idiosyncrasy, or what Virchow has called the "mystery of individuality," the same drug generally causing the same form of eruption in the same individual, and it is an interesting fact that such idiosyncrasy may be hereditary.

The entrance into the circulation of vaccine matter and so-called septic material is also competent to excite pathological changes in the skin. In vaccination,

besides the more common and localized eruptions of erythema, eczema, and erysipelas, which start from the point of inoculation and spread by continuity, there sometimes occur exanthemata, which, appearing after a certain period of incubation, upon regions of the body distant from the point of inoculation, often resemble in appearance angio-neurotic eruptions, and are apparently due to entrance into the circulation of vaccine matter, or possibly, in some cases, as Behrend supposes, of the products of suppuration which has taken place at the point of inoculation. During the course of diphtheria and other septic processes, and notably puerperal fever, there not unfrequently occur eruptions of the angio-neurotic type, being made up of erythematous and urticarial lesions, and probably the so-called puerperal scarlet fever and the "scarlet fever" after operations are of a septic nature, and not genuine scarlatina. Bullous, and very commonly purpuric, lesions may also ensue in consequence of septic infection, and several observers have expressed the opinion that all cutaneous lesions, occurring as a result of such infection, are metastatic in character; and although this may not be true of all, it is not unlikely that the petechial lesions are of this nature, namely, hæmorrhagic infarcts of the skin caused by plugging of its capillary blood-vessels by emboli composed of micro-organisms, more especially as some recent microscopic observations, by Watson Cheyne, of the lesions occurring in purpura hæmorrhagica seem to confirm this idea.

In the cases already considered, the foreign material, or *materies morbi*, which excites cutaneous manifestations of its presence in the system, is introduced into the organism from the outside, and this may also be said of the acute and contagious exanthemata, of typhus and typhoid fever, of glanders, of syphilis, of the oriental pest, and of infectious maladies, where cutaneous eruptions are exceptional and not characteristic of the disease, such as cholera, relapsing fever, and acute miliary tuberculosis; but instances are not wanting in which similar appearances may be caused by the formation in the organism itself of material which by its presence in the blood is competent to give rise to changes in the skin, and examples of this are furnished by scurvy, uræmic poisoning, and diabetes.

Chemical examination of scorbutic blood shows, besides other changes in its composition, increase in the amounts of water, fibrin, and albumin, and decrease in the quantity of its globular elements, and these changes, which are apparently caused by exposure to hardship combined with deprivation of certain articles of diet, notably fresh vegetables, are attended by the development of purpuric lesions in the skin and hæmorrhages into other tissues of the body. There is no reason for supposing scurvy to be an infectious malady, and the suggestion that the purpuric lesions of the disease may be due to the influence of the same micro-organisms which are ordinarily harmless denizens of the mouth and other cavities of the body, but which in these cases are furnished with unusual opportunities for growth and development on account of the altered composition of the blood, is a curious instance of bacterio-mania.

In chronic diminution or complete arrest of the renal functions, the consequent retention in the blood of waste products which should be eliminated by the kidneys usually manifests itself by headache, symptoms of gastric disturbance, and in severe cases by coma, but occasionally there are likewise produced cutaneous symptoms, consisting of a papular form of erythema, attended with exudation and followed by desquamation, which has been described under the name of erythema uræmicum. This form of eruption usually makes its first appearance upon the extremities, notably upon the extensor surfaces, and subsequently spreads to other parts of the body. Confluence of the original lesions sometimes

causes the eruption to assume a likeness to that of scarlet fever, and in one case of unusual severity bullæ and purpuric lesions were formed in the skin, and hæmorrhages took place into the mucous membrane of the mouth.

The cutaneous manifestations which occur during the course of diabetes, apparently in consequence of the overproduction of sugar in the system, have been made the subject of a special article by Kaposi, and may be of the angio-neurotic type represented by roseola, erythema, and chronic urticarial lesions, or of a more frankly inflammatory nature, consisting of furunculosis, carbuncular lesions, and even gangrenous dermatitis. The presence of sugar has been demonstrated in these inflammatory lesions, which call to mind the similar cutaneous changes caused by iodine and bromine.

The eruptions which have thus far been mentioned are, properly speaking, not diseases *of* the skin, but changes *in* the skin, which are symptomatic of the presence in the circulation of some material which is foreign to the organism, and which either enters into it from without or is the result of perverted and incomplete performance of its physiological functions. In a crude way they may be arranged in three groups, namely: those of an angio-neurotic nature, represented by the various forms of erythema and urticaria; those of a reactive inflammatory and suppurative type, consisting in acneiform, furuncular, and carbuncular lesions; and those of a hæmorrhagic variety, manifested by purpuric eruptions, and it is worthy of notice that eczema, which is so common a disease of the skin, is so rarely met with in this connection.

The pathological changes in the skin, which are regarded as cutaneous diseases properly so called, are not unfrequently purely symptomatic in their nature, and a rational method of treatment does not lose sight of this fact, although the exact indications to be met are often obscure or entirely unknown.

The acute outburst of urticaria, sometimes accompanied by vomiting and febrile symptoms, which occurs after the use of certain articles of food in susceptible individuals, has its exact counterpart in the similar eruption following the use of various drugs, and many strange examples of such personal and gastronomic idiosyncrasy are recorded. The typical and self-limited course of erythema multiforme, erythema nodosum, and certain varieties of purpura; the prevalence of these diseases during the spring and autumn; the individual susceptibility which renders the patient liable to renewed attacks with the return of these seasons; the general feeling of languor and debility and arthritic pains which are often evident, and the occasional development of cardiac murmurs during the course of these maladies, all go to show that their cutaneous lesions are merely symptomatic of some general and possibly infectious influence, the exact nature of which is entirely hypothetical.

The chronic varieties of erythema and urticaria, on the other hand, which by recurring attacks form such an unpleasant feature in the existence of the sufferers therefrom, are symptomatic of some disturbance of the various physiological functions of the body, and external applications have upon them but a temporary and palliative effect. They may often be associated with manifest symptoms of dyspepsia, with costiveness, and with improper modes of living, in which case the appropriate and generally effective remedy is to set right whatever is wrong, so far as lies in our power. The evil effects of the incomplete performance of the digestive and excretory functions are not limited to symptoms referred to various parts of the alimentary canal, and may even make themselves felt without any marked manifestations of the latter, and the lassitude,

drowsiness, and general debility so often met with in these cases are probably but milder manifestations of changes in the blood which may even result in symptoms of coma, such as have recently been described as following, and probably caused by, dyspepsia. A sedentary life in a vitiated atmosphere, and improper food, are to many the ordinary conditions of existence, and plenty of fresh air, physical exercise, and regulation of the habits and diet are often more called for than drugs; but occasionally instances are met with where there is no obvious derangement of any but the cutaneous system, and where the functions of digestion and elimination are performed with regularity and apparent completeness, and consequently our therapeutic efforts must sometimes be made at random. But the facts which come within the narrow limits of personal experience, that such cases are sometimes much relieved or even cured by the administration of salicylate of soda, atropia, or by a thorough-going course of purgative waters, are suggestive of future possibilities in the way of therapeutics, when our knowledge of the action of drugs and the indications for their employment is more exact than it is at present. There is no doubt also that eczema and other cutaneous disorders, which are not so purely symptomatic in their nature as those already mentioned, may be aggravated and kept up by similar conditions of the system, and a strict attention to the functional integrity and vigor of the body, in addition to local treatment, is often necessary to secure a successful result. Disturbance of the nervous system and exudative or inflammatory tissue changes are but the machinery of pathology, which is set in motion by what in the broadest sense of the word may be called irritation, and doubtless one form of such irritation is change in the composition of the blood by quantitative or qualitative modification of its various constituents, or by the introduction of foreign material, and the patient who makes the traditional demand for its purification may, in many cases, be nearer the source of his malady than the physician who is busy with the symptoms. However clumsy and ineffectual our therapeutic efforts may be, they should not be employed without a clear recognition of the close relations existing in matters of pathology between the body and its cutaneous envelope, which renders dermatology, of all the special departments of medicine, the least independent of general pathological states of the system.—GEO. H. TILDEN, *Bost. Med. and Surg. Jour.*, July 23, 1885.

Received.

Treatment of Eczema, by HENRY J. REYNOLDS, M.D. (Reprint).

Mittelbare Uebertragung des Ulcus Molle, von DR. EDMUND LESSER (Reprint).

Ueber Lepra in Norwegen und über einen Fall von einheimischer Nervenlepra von PROF. DR. EDUARD LUNG (Reprint).

La Lèpre et son Traitement, par le DR. E. VIDAL (Reprint).

Des Nodosités non erythemateuses chez les Arthritiques, par le DR. L. BROCCQ (Reprint).

Etude sur le Mycosis Fongoïde, par E. VIDAL et L. BROCCQ (Reprint).

Die Elephantiasis Arabum, von DR. H. VON HEBRA (Reprint).

Item.

PATENT HAIR RESTORATIVE.—Mr. Rudolph Damann has recently procured a U. S. patent for a "composition of matter to be used as a hair restorative, consisting of lime, plumbago, borax, beeswax, tallow, salt, lac sulphur, and coal oil."

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Original Communications.

ANGIOMA PIGMENTOSUM ET ATROPHICUM, *TAYLOR*.
MELANOSIS LENTICULARIS PROGRESSIVA, *PICK*.
LIODERMIA CUM MELANOSI ET TELANGIECTASIA, *NEISSER*.
XERODERMA PIGMENTOSUM, *KAPOSI*.
DERMATOSIS KAPOSI, *VIDAL*.¹

BY

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IT is my purpose to present a brief account of two cases of this disease which have lately come under my observation. This peculiar affection, characterized by so many and so striking pathological processes, has been so ably studied of late by such competent observers as Neisser, Vidal, and Pick, and its appearances so well pictured by the latter two, that little remains for me but to add this report of additional cases to the lists published by them.

The cases occur in a family of Russian Polish Jews. The parents have lived in Russia, England, New York, and Boston. The mother is a healthy-looking woman, stout, of fair complexion, dark-brown hair and eyes. She says that she has always been well. The father, by the wife's report, is a blond with light hair and eyes. No such disease has occurred previously in either family to their knowledge.

The boy Louis came to the Massachusetts General Hospital Out-patient Department, July 27, 1885. He was asked if there were other cases in the family, and on the statement that a little brother had the

¹ Read at meeting of Amer. Derm. Association, Aug. 26, 1885.

same disease, he was told to come on the following day with him and the mother. Drs. Greenough and Tilden were present by invitation. The mother gives an account of her children as follows:

1st child, girl. Died at age of 12 of fever. Skin unchanged.

2d child, boy, æt. 17. Case 1.

3d child, girl, æt. 15. Skin unchanged, eyes and hair black, has few freckles.

4th child, boy, æt. 11. Skin unchanged, eyes blue, hair brown.

5th child, boy, æt. 5. Skin unchanged, eyes and hair black, skin deep olive.

6th child, boy, æt. 3. Case 2.

7th child, girl, æt. 1½. Skin unchanged, eyes blue, hair brown.

This condition of the family was confirmed by a subsequent inspection.

CASE I.—Louis Berriek, æt. 17. The mother first noticed a change in the skin before the child was two years old, and while they were living in Poland. A few freckles, as they were then supposed to be, appeared upon the face and later upon the hands, which increased in numbers up to the age of six, when the family emigrated to England, leaving Louis behind. He was not seen by the mother again until two years ago, an interval of nine years, when he joined the family in Boston. At that time the melanoderma was nearly as marked as at present, but the leuoderma was just beginning to develop, and has been steadily increasing in area since then. When the telangiectasic condition appeared is not known, but the mother thinks that it was as noticeable when he rejoined the family as now.

The patient as an infant was well developed and always healthy. As a boy he continued to have good health, but has grown slowly, and is now not larger than a boy of twelve years. The muscular tissue is firm, and the genitals, although small, are well developed. The hair-growth about them is scanty, but upon the scalp it is very thick and of an intense blackness. The eyes are also very black. It is impossible to determine with certainty the natural color of the skin, so universally has it become affected by the disease.

Present appearances: Melanosis.—The forehead, cheeks, lower face, and neck are of a very dark brown, apparently uniform in tint, but on close inspection small darker spots are seen to cover the parts very thickly, resembling strongly the skin of a badly freckled dark mulatto. The tint of the whole trunk is as dark as that of a dark Spaniard, and superimposed there is a dense spattering of a still darker hue, least noticeable over the central abdominal region, but nowhere absent. The scrotum is very black, and the penis and glans present sparse, but very dark spots. The arms, particularly the extensor surfaces, are very thickly spattered, and the hands are very deeply colored and bespotted, some of

the blotches here being of an intense blackness. The nails present a natural appearance, and the palms are unspotted. The thighs, like the trunk, are of a lighter tint and more sparsely freckled, but one of them presents upon its inner surface an almond-shaped blotch of the deepest black, slightly elevated, smooth, and sparingly covered with a hair-growth of considerable length. The lower legs are very dark and thickly occupied by blotches of larger size and blacker color than elsewhere. The mucous membrane within the mouth and larynx (carefully examined by Dr. Langmaid) is free from melanosis.

Atrophic or leucodermic condition.—On the right side of the face, occupying at least one-half of its surface, is a sharply defined area entirely without pigment. Similar areas are seen upon the other cheek, the forehead, and about the mouth. The surface of these parts is smooth, and has a stretched, glistening appearance. In places the skin thus affected has a pinkish hue, and the deep veins are readily seen within it. The integument here is apparently thinned, and resembles superficial scar tissue. The ears are very thin, but show no loss of cutaneous pigment. They resemble tanned sheepskin. No leucodermic patches, but a few minute white dots are seen upon other parts of the body. The striking contrast between the white areas upon the face and the intense blackness from which it is so abruptly separated, gives it an indescribable appearance. The sensibility of the atrophic districts, tested by Dr. James J. Putnam, is decidedly impaired. Touching them with the end of a string was unrecognized by the patient, although the prick of a pin was appreciated. The sweat glands are less active in the leucodermic areas.

Telangiectasis.—Over the central parts of the face there are numerous bright-red, slightly elevated spots, varying in size from a large pin's head to a small pea. They are most noticeable and abundant in the leucodermic patches, on the lips, and about the edges of the eyelids. Within the lids near the edge are two angiomaticous new-growths, more elevated than those of the integument. A few of the red spots are seen upon the ears and the backs of the hands, but they are not very conspicuous. Several greatly enlarged vascular twigs are also noticeable upon the face, especially upon the alæ of the nose. On very close inspection, a few minute red points may be discovered over the general surface.

The vascular hypertrophy cannot be represented in the accompanying woodcut.

CASE II.—Iza, a well-grown boy, 3 years old. He was born in New York. When he was 18 months old, his mother for the first time noticed a few light-colored freckles upon the face, which largely disappeared during the following winter. Since then the present appearances have been gradually developing. The hair is rather dark brown, the eyes are black. The tint of the skin is brunette. The mother says

that the eyes of both these children are very weak, during the summer especially. Those of Iza appear very sensitive when directed towards the window. The mental condition of both seems to be normal. The face is universally covered with small, deep-brown freckle-like spots on a general brownish ground. A few of them are deep black. The spots are so small and thickly distributed that at a little distance the face looks as if deeply and uniformly tanned. In some parts they are slightly thickened and rough to the touch, as patches of keratosis senilis. The backs of the hands and wrists are uniformly covered with innumerable, very small, faintly brown spots. Elsewhere the skin is of its natural color. There are no leucodermic patches and no telangiectasis.

Of the correctness of the diagnosis in these cases there could be no question at the first glance to one familiar with the descriptions of the affection. Three of the distinct pathological processes which characterize it are present in the oldest patient in a marked degree: the melanosis, the vascular new-growths, and the superficial atrophy of the skin. There is lacking only the almost constant, final transformation into carcinoma. In the second case, seen in the near beginning of the disease, we have only one condition present, namely, the pigmentation. From a careful study of this in its inception, and of the parts last affected in Case I., I conclude that the disease begins, or at least has begun in them, with an excessive formation of pigment in the shape of minute points; that these points enlarge and take forms in no way to be distinguished individually from ordinary freckles. They appear to be evanescent at this stage, like the latter, and affect, like them, parts most exposed to light; that is to say, the melanoderma begins to manifest itself upon parts of the skin naturally prone to just such irregular pigmentation in childhood. It occurs, too, with just the same absence of all unusual subjective or objective precedent or apparently causative phenomena, as in lentigo. In these cases, there had been no exceptional exposure to sun or visible hyperæmia before the beginning of the melanosis. Gradually the lenticular spots multiply until large surfaces are entirely occupied by them, but never so as to form uniform areas of considerable extent, as in other forms of melanoderma, the skin always appearing spotted or blotched with well-marked lentiginous shapes. They advance slowly and regularly, too, from the face, hands, and feet towards the central parts of the general surface, thus allowing an easy study of the course of development of this feature of the disease. It is probable that several years, certainly two, may pass, and no other manifestation of the disease present itself. Case II. shows that within two years from its start, the pigment cells may increase so much faster than they are removed by the natural process of desquamation that they may heap themselves up and form marked elevations, and that a verrucose,

papillary hypertrophy may develop beneath such pigmentary keratoses within the same period. In Case I., on the other hand, we have the disease in progress for fifteen years without any such accumulation of pigment cells or papillary hypertrophy; but only a single, small, flat, somewhat elevated *nævus pigmentosus et pilosus* of uncertain duration as an indication of advanced pigment change.

How early the telangiectasis appeared in Case I. cannot be ascertained. It is now most apparent in the part longest the seat of the melanoderma, viz., the face. It is nowhere present upon parts last affected, nor has it yet developed in Case II. after eighteen months of melanosis. These observations led me to the belief that it is a secondary condition, certainly not necessarily the initial process, nor even coincident in some cases. It is by far most developed in Case I. in the areas of atrophied skin, as if developed there anew, as in some cicatrices, or, at least, as if left behind unaffected by the atrophic process. Telangiectasis is not a common sequence of melanoderma in any of the many other forms of the latter, nor are the ordinary, superficial, vascular new-growths of the skin, the enlarged vascular twigs, the "spider cancers" ever followed by pigmentation. The two processes seem, therefore, to have no real pathological association. I exclude from this class of phenomena, of course, the melanoderma which may follow diffused hyperæmia of all grades.

In this connection, however, I must appropriately refer to a case which came under my observation two years ago for a very brief period. It was a woman, 28 years old, who, five years previously, during pregnancy, noticed the development upon her face of numerous telangiectases, or red spots, as she called them, which disappeared largely after confinement. The following year she again became pregnant, and the "spots" re-appeared and remained. She believed that they had been increasing in number since then, but that some of them had vanished and had left behind them brown spots; at all events, brown spots had been appearing in a very conspicuous manner. The forehead and upper face, especially in the vicinity of the eyes, were very thickly occupied by linear and lentiginous-shaped, discrete telangiectases of a very brilliant hue. Interspersed with them were numerous freckle-like pigment spots of all shades, varying from a light buff almost to black. They were also thinly scattered over the cheeks and upon the sides of the neck. The patient had never before exhibited freckles. I could see no evidence of a transformation of a telangiectasia spot into melanosis, or *vice versa*. They appeared entirely independent of each other in position and development. There were no atrophic areas. The appearances as a whole were very striking, and I was in doubt whether to regard them as an exceptional instance of the disease we are considering or not.

Neither in these cases do I observe anything which shows the transformation of an individual pigment spot into a telangiectasis, or *vice versa*, nor is there any necessity of such a presupposition. Both processes are very common ones in themselves, and, as already stated, have ordinarily no such relationship or even association. The new-growth of blood-vessels certainly underlies that of pigment, and in my cases is certainly subsequent to it. The two processes may be regarded as no more closely allied than associated or coincidental features of a strongly marked pathological condition of the skin.

Nor can the date of the beginning of the atrophy in Case I. be ascertained. It occupies considerable areas, and has without doubt been in progress for several years. The atrophy embraces a large part of the thickness of the integument, as shown by the thinning of the alæ of the nose and of the ears—parts which permit the loss of tissue to be readily estimated. I should judge that the papillary layer with the underlying superior plexus of vessels at least had wholly disappeared, and that the glandular structures had also mostly perished. The follicular openings were no longer apparent. The relation of this atrophy to the two processes above described is to me incomprehensible. We know that some forms of abnormal pigmentation of the skin are capable of self-involution, that others involve the tissue in which they are deposited in exceptionally rapid destructive processes, that others have an intimate association with carcinomatous disease, and that in some varieties or instances of morphea we do have the close combination of melanoderma, vascular hypertrophy, and atrophy of the skin also, but the observation of these facts affords no satisfactory explanation of their occurrence. The *atrophia cutis* must be ranked as step three in the history of the disease.

That two more processes are likely to be developed in the future of Case I. is more than probable, viz., hypertrophy of the epithelial and papillary layers, and later a transformation of the same into epithelioma. This has been the sequence of tissue-change in so large a proportion of the thirty-three authentic cases thus far tabulated by nine observers, and embracing only individuals of a dozen families, more or less, that this grave prognosis can hardly be avoided in so well-marked an example of the affection.

I have but a word to add concerning the title of the disease. From my limited opportunity of study, I consider that recommended by Dr. Taylor, and adopted by our Association, *angioma pigmentosum et atrophicum*, as ill chosen in some respects, for I cannot regard the *angioma* as first in importance of pathological significance, or deserving priority as the initial lesion. The term *melanosis* seems to me in these respects to deserve precedence. The additional terms *lenticularis* and *progressiva*

of Piek are significant, but for descriptive titles not sufficiently comprehensive. We should go further, if we would thus completely define it, and add *telangiectodes* and *atrophica*. It is to be regretted that some single name, arbitrarily selected, if need be, should not be adopted for a disease so remarkable in its complex and exeptional diversity of tissue-change and protracted progression.

ON THE RELATIONS OF LUPUS VULGARIS TO TUBERCULOSIS.

BY

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(Continued from page 335.)

IT is scarcely necessary in this connection to enlarge upon the admitted fact, that up to the present date the investigation of the relations between lupus vulgaris on the one hand, and the several conditions described as tuberculosis and struma on the other, has had the result of establishing two different schools of belief.

The opinions of the first to be described are represented in the earlier writings of Fuchs and Plumbe, by a large number of French authors, including the distinguished names of Bazin, Devergie, Hardy, and more recently that of Besnier; by the late Sir Erasmus Wilson and a number of other prominent writers of Great Britain; and in this country, in our own day, by several of our colleagues. The views they have entertained differ in minor particulars, but in the main all have been agreed as to the relation between the diseases in question. They have held to the doctrine, that before there could be a lupus or a serofuloderm there must have been a systemic condition, which etiologically explained the local disorder. This systemic condition, illy defined, it must be said, by the very ablest exponents of this theory, was held to be a species of physical vice, inherited or acquired, more frequently the former, indueing in its subjects a remarkable deviation from the normal processes of nutrition, development, and reproduction. They thus set aside, as it were, in one great pathological family a large number of the human race, who were doomed, if they became the victims of accident or disease, to certain consequences from which all their fellows were exempt. No need to-day, surely, to go over the ground which has been slowly rescued from this enormous domain. Dismissing all the loose statements and all the erroneous diagnoses which have been made under cover of these teachings, we now know that much of this field has been properly assigned to

syphilis, and another part to disorders which cannot to day be regarded as having a constitutional origin. Thus restricted, the ground has been held, and often well held as regards the strict relation between *lupus vulgaris* and what is termed *scrofula*. While one party in this school has contended that *lupus*, *struma*, and *tuberculosis* were different manifestations of a single disorder; and another, that they were merely allied and related members of a single family; it cannot be denied that all were in practical agreement as to the constitutional origin of the several disorders thus claimed to be identical or related. Before there could be a *lupus*, there must be an antecedent *scrofulous* cachexia, diathesis, vice, or predisposition. No one of these advocates, as far as I can discover, has ever printed a line, or uttered a suggestion, upon which could be based an argument in favor of an infection of the system beginning as a strictly local disorder, a primary *scrofulosis* so to speak, entirely unconnected with a systemic state. A few quotations may serve to illustrate this point:

Devergie,¹ for example, wrote: "If an *eczema* manifested in youth possesses a special physiognomy, it is essentially *scrofulous*, and can only be cured by modifying the constitution."

Hardy,² also, states that the "cutaneous manifestations of a general condition are called *scrofulides*."

Besnier and Doyon³ express themselves as follows: "What are *chlorosis*, *anæmia*, *dysmenorrhœa*, *seborrhœa*, *sterility*, *chronic catarrh* of the pulmonary apices, and *incipient tuberculosis*, if not diverse manifestations of the same constitutional cause?"

Thus also the late Sir Erasmus Wilson⁴ wrote: "*Scrofula* or *struma* is a state of the animal constitution."

And lastly, Dr. Piffard⁵ describes the "*scrofulides*," as "affections which are the outward manifestations of a general constitutional condition or diathesis, which diathesis may be hereditary or acquired, and last indefinitely or for life."

The second and opposing school of belief in this discussion has denied positively a relationship between *lupus vulgaris* and a *tuberculo-strumous* diathesis. This denial has been for the most part based upon the sufficient clinical facts to which attention has been called above. Their views were best expressed by Hebra, and have been stoutly maintained by his followers since his teachings first received support in the scientific world.

¹ "Trait. prat. des Mal. de la Peau," Paris, 1837, p. 630.

² "Maladies de la Peau," Paris, 1866, p. 18.

³ Notes to their French translation of Kaposi's "Treatise on Diseases of the Skin," Paris, 1881, p. 247.

⁴ "Lectures on Dermatology," London, 1875, p. 31.

⁵ "Diseases of the Skin," London and New York, 1876, p. 52.



Dr. White's Case of Xeroderma Pigmentosum.

A careful study of the written opinions of most of the Vienna school of dermatologists discloses the important fact that, while thus denying the etiological relation between the diseases under consideration, they put forward no theory of their own as a substitute for the other. They did not contend that they or others had solved the problem. In this confessed ignorance they contented themselves simply with further study of the disease. They established firmly the clinical facts set forth in the record of the cases here collated. These facts are as old as the study of the disease itself. It is these that, even in the present state of our knowledge of the subject, have constrained Doyon to call lupus a "form" of tuberculosis merely; Walter Smith, to name it a "variety" of the same disorder; Neisser, to use the expression, "a partial manifestation" of tuberculosis; and Baumgarten, Schüller, Friedlander, and others, to advance arguments by which these facts might be either offset or explained. These same facts show incontrovertibly that the subject of lupus vulgaris may be born of sound parents, and have a family record in which for generations there may be no trace of lupus, struma, or tuberculosis. He or she also may reach maturity and never suffer from any disease of consequence save always the lupus. He or she may marry, procreate healthy children who may accomplish the same physical destiny without exhibiting signs of an inherited disorder. Finally, these subjects of lupus vulgaris may die at an advanced age of some accident or intercurrent disease. With these facts in mind, we can with ease explain such a case as that lately reported by Doutrelepon, for example,¹ in which the subject of lupus vulgaris developed also a tubercular meningitis. Neither can it be difficult to account for the experience of Besnier,² as lately published by him, eight of whose thirty-eight patients affected with lupus, had also tuberculosis. The mere circumstance that it has become necessary to publish such reports is the strongest commentary upon their rarity. But these figures, however correctly they may represent the ratio of concurrence of lupus and tuberculosis in France, can in no sense be accepted as expressing the percentage of such coincidences in this country. The strength of the clinical argument against the views entertained by the French School of authors is as unshaken to-day as when Hebra's earliest doctrines on this subject were first given to the scientific world. They will so remain while the mass of mankind continues to live with its present social environment. Whatever exact relations may hereafter be established between lupus vulgaris and tuberculosis, the majority of patients suffering from the one disease will certainly never exhibit the symptoms of the other.

But we are suddenly and recently confronted with a revelation for

¹ Deutsch. Med. Wochen., No. 7, 1885.

² Annales de Derm. et de Syph.

which we are indebted to the labors of the pathologists, which throws a flood of light upon this and its allied questions. Koch was first to recognize the bacillus tuberculosis in flaps of lupous tissue, and subsequently cultivated these same bacilli outside of the living body, producing lastly tuberculosis in the tissues of some of the lower animals by injecting them with these culture-fluids. He has been followed by Doutrelepon, Weichselbaum, Meisels, Lustig, and others, who claim to have repeated his experiments and thus verified his conclusions. A large part of the scientific world to-day holds that the correct explanation of the question at issue has been reached. To my mind it furnishes the only adequate solution of the problem which is possible, and demonstrates the fallacy of the position occupied heretofore by the adherents of the school of observers first described above. Curiously enough, one of the most earnest champions of the old theory of the constitutional origin of tuberculosis and lupus is to-day calling attention to the alleged confirmation of this theory by the later pathologists.

But the moment that we examine the bearings of these newly-demonstrated facts, we find that they are far from lending support to such doctrines. They place before us the disease whose etiology has been long unknown, as a strictly infectious and parasitic disorder. Given proper conditions for infection by transference of the parasite, and we find persons of perfectly sound health exhibiting the signs of the disease. According to this view, lupus vulgaris never results from such a systemic cachexia, vice, tendency, or diathesis, as has been believed and taught, but is always at first, and possibly even throughout its evolution, a strictly local disorder, unconnected with any involvement of the system. This limitation to the skin and to certain parts or regions of the skin is due to the unfavorable local conditions here supplied for the development and multiplication of the infectious germs. This development, however slowly proceeding, and this multiplication, however unfavorably conducted in the skin, is characterized by a rapid progress when occurring in the warmer and more delicate endothelium of the pulmonary alveoli. The primary point of points of infection by the lungs are the more frequent sites of this accident, by as much as they are more favorably situated for the culture of the parasite. It follows necessarily, and I think it important to call attention to this point, that just as we may find several simultaneously-infected points upon the skin, as when lupus vulgaris exists both on the face and on one or more of the extremities, so we may have exceptional and rare cases in which the skin may be infected with lupus and the lungs later with a pulmonary tuberculosis. We must insist upon this possibility with all of the bearings in every anomalous or exceptional case. If the lupus of the skin be due to an accidental infection at one or more points, and pulmonary tuberculosis be merely another

accidental infection of another organ of the body, before it can be held that the one accident is in any way related to the other, the possibility of simultaneous occurrence of such accidents must be set aside. Or, to state the question somewhat differently, it is more reasonable to assume that the bacilli claimed to produce lupus gained access to the lungs precisely as they gained access to the skin, than to assume, first, an access to the skin, second, a constitutional involvement and a resulting general cachexia; and, third, an infection of the lung as a result of the latter. Already we can discover dawnings of this truth in the claim set forward that true tuberculosis of the skin is always the result of a tuberculosis of the system at large; while lupus as a primary lesion differs in a marked degree from this species of tertiary lesion of bacillus-possession.

Let us look for a moment somewhat in detail as to the mode by which this parasitic etiology of lupus vulgaris explains many of its clinical features.

First, the patient affected with the disease may be perfectly sound, with an unimpeachable family record, and free from any demonstrable constitutional vice. The disease, from the first day to the last, may be purely and solely a skin disease, the parasite in this case attacking the skin only, and leaving the other organs sound.

Second, lupus vulgaris, certainly in its inception, is a disease of childhood and not of infancy. It is rarely apparent before the third year of life.

At this period of existence, the child has really emerged from the infantile state and has usually completed its first dentition. As a rule, it is no longer subjected to the daily complete ablution of the body given by the mother to a young infant, and in its waking hours is no longer the object of an incessant attention. Often, indeed, a subsequent pregnancy or the birth of a younger child has operated to transfer a large part of the care it originally received, to the person of a younger brother or sister. In this connection it would be highly interesting to discover how many patients affected with lupus vulgaris were eldest children.

The child thus situated has reached that period of life when education has not had opportunity of establishing the habits of cleanliness, and is quite unprovided with an instinct enjoyed by the young of many of the lower animals, which at intervals assiduously cleanse the entire surface of the body by the aid of claws, talons, beak, tongue, or teeth. By nature many of its habits are filthy; and when it is neglected, it often surpasses in uncleanness many of the lower animals. Its hands are brought into contact with the accessible parts of the body with fully as much freedom when soiled as when unsoiled, in the act of picking, scratching, and rubbing. Its amusements and close personal contacts are chiefly

with children of a like age, as unprotected as itself from the accidents of infection. Much of its time is spent on the floor or upon the ground, even when in active movement. In this way, not only the traumatisms that are self-produced, but those inflicted by accidents related to its feeble steps, uncertain use of muscles, and sudden impulses, are so many sources of danger.

Third, the several sites of *lupus vulgaris*, as thus developed in childhood, are precisely those to which attention would be directed by the play of the hands and by the commonest contacts with foreign bodies. Thus the relatively short upper extremities of the child reach without difficulty to the portions of the face below the line of the brows, especially to the nose, the cheeks, the lips, the ears, and the chin, most frequent sites of *lupus vulgaris*; while the rarer of the cephalic sites, the brows, the scalp, and the nucha, are incontestably less accessible.

Again, at the age under consideration, it is common, at all times in warm latitudes, and during the summer in colder climates, to leave the upper and lower extremities exposed, the feet being bare, and often the legs below the knees, while the arms, from the elbows down, including the hands, are similarly uncovered. It is scarcely necessary to say that these are the situations where *lupus vulgaris* of the extremities, the next site of predilection of the disease after the face, is usually developed. Recognizing the fact that females are in slight preponderance as regards the frequency of infection by *lupus*, it would be interesting to discover whether *lupus vulgaris* of the extremities is not more common in the male sex, boys being more often than girls permitted to go with the feet and legs uncovered. The only case of *lupus vulgaris* of the extremities collated in the preceding pages occurred in a male subject. We note here, too, that as in the eczemas of several of the trades, the tender and more delicate surface of the back of the hand and foot is more commonly the seat of the disease than the thicker palmar and plantar tissues, which, if involved, are commonly reached by extension of a serpiginous lupous infiltration from the other parts named.

Next in order of frequency come the buttocks. These are not only accessible to the hands of the child, but are often as much exposed as the hands and the feet to accidental contacts when the child is seated on the ground or upon the floor, often, indeed, being at such times quite uncovered by the dress.

Again, at the period of life reached by the child whose habits we are considering, the sexual instinct is dormant, and there is almost no solicitation to carry the hands to the genital region of the body. The character also of the dress usually worn at this age is such as to generally require the aid of a nurse or attendant to completely expose the parts. We are thus not surprised to learn that *lupus vulgaris* of the genital region is

of exceedingly rare occurrence, and when so situated is usually reached by extension from the thigh on the one side or on the other, or from the belly above.

Fourth, lupus vulgaris is not recognized as an inherited disease. The new doctrines held on the subject of pulmonary tuberculosis, since the later investigations of its etiology, point decidedly to new infection of the children of phthisical parents rather than to an inheritance of a parasitically begotten disease. The evidence employed to induce belief in the possibility of inheriting lupus vulgaris would not be regarded as admissible in any court of evidence governed by the common law.

Fifth and lastly, the obvious tendency of lupus vulgaris to a strictly cutaneous limitation is not without analogy in other disorders of the skin produced by diseases that may involve also other organs. Syphilis furnishes such an analogy, and that whether we accept or not the recent claims set forth by Lustgarten and others, that syphilis is a disease also produced by a species of bacillus. The more dangerous of the syphilitic visceral troubles rarely occur in those who have suffered from the severest skin lesions. By "severe skin lesions," I do not mean the formidable ulcers only that form, usually few in number, after the degeneration of gummata, but those rare cases most like lupus-forms, where the entire surface of the body has been for years the seat of an extensive serpiginous ulceration, seaming the integument with scars from the head to the feet. These are rare cases, chiefly probably because the disorder is so amenable to treatment that it is rarely permitted to have such sway, but such cases are occasionally seen by the expert where the disorder has been either unrecognized or untreated. In every one of the cases of very extensive involvement of the skin with syphilitic ulceration that have come under my observation, the bones and viscera have been spared. Yet I lately saw the liver, spleen, and brain studded with gummata in the case of a subject dead of syphilis after six months of infection, with the most trifling of cutaneous accidents. Indeed, it is well worth inquiring whether the well-nigh abandoned syphilization processes did not accomplish much the same end by keeping the skin in a constant state of efflorescence, as far as was possible, by the aid of indefinitely multiplied traumatisms.

TREATMENT OF CICATRICES OF THE FACE.—In the treatment of cicatrices of the face, particularly of the lower jaw, all unsightly scars may be avoided by using a dressing of perchloride of iron, ʒ i.; collodion, ʒ ij. Let the cicatrix be cut clear off and the dressing applied every day, and a barely perceptible line will be the result.—DR. GENESE *Id. Med. Journal*, Sept. 12, 1885.

DERMATOLOGICAL NOTES.

BY

C. M. G. BIART, M.D.,

Omaha, Neb.

Inherited Keratosis of Palms and Soles.

IN the May number of this JOURNAL, Dr. G. H. Fox reported a case of the above disease. Mr. B. came to me for the relief of the same trouble. The condition of the palms and soles was such as to allow only of an insignificant amount of motion. This condition has existed since infancy. His brothers and sisters were all similarly afflicted. The disease in this case was inherited from the father, who, together with his brother, suffered also with keratosis of the palms and soles.

Electrolysis.

I would like to call attention to the destruction of chaneres by electrolysis. This operation is original with me—at least I am not aware of any one having performed, reported, or suggested it. The results, in the cases on which I have operated by this method, have so far been very gratifying, and have led me to consider it preferable to excision. The electrolytic process has probably a destructive action on the virus beyond the seat of actual destructive tissue, whilst in excision a certain amount of tissue only is removed—without any influence beyond the line of incision—and which may or may not include the entire virulent mass, thus accounting for varying results. This operation by electrolysis was undertaken with the view of ascertaining whether or not the initial sclerosis be purely local, which I am inclined to believe, or merely a symptom of constitutional syphilis. I reserve a subsequent paper on this subject for the time when sufficient evidence will have been collected to justify its appearance.

Ethereal Solution of Caoutchouc.

Lately I have been using the above solution with satisfaction. The ether (I use Squibb's) is less irritating than the chloroform in the liq. gutta-percha and the caoutchouc preparation is also more elastic than collodion. Hence the caoutchouc-ether solution is preferable to either collodion or traumaticine in certain cases. A quantity of this solution, mixed with ointments and spread upon muslin, makes a very good adhesive dressing.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

157TH REGULAR MEETING, OCTOBER 27, 1885.

DR. W. T. ALEXANDER, *President, in the Chair.*

DR. FOX presented a

CASE OF LUPUS ERYTHEMATOSUS.

Eliza M., 51 years old. The present eruption made its appearance eighteen months ago on the head, and soon after on other parts of the body. Previous to that she was free from any skin lesion whatever. The patient now has red, scaly, and irregularly oval patches upon the chest and under both breasts; there are some large, scaly papules on both elbows. Upon the back, near the upper border of the left scapula, is a sharply circumscribed oval patch, with an irregularly raised surface. Behind the right ear is a small ulcer with raised edges. There are also scaly spots in the hair. The eruption has always been dry, forming scales, which are shed off. There is no itching.

In presenting the case, Dr. Fox said the diagnosis of lupus erythematosus, rodent ulcer, and psoriasis had been made by various physicians.

DR. BRONSON did not think the case was lupus erythematosus, but eczema; he had never seen the former disease present a moist surface. Some of the patches, especially the one behind the ear, he considered to be epithelioma.

DR. JACKSON believed that the lesion behind the ear was an epithelioma, that on the body lupus erythematosus.

DR. ROBINSON said that the eruption behind the ear was an epithelioma, and based his diagnosis on the waxy appearance of the lesion and its raised margin. He was not prepared to diagnose the eruption upon the body.

DR. ALEXANDER said that he had seen the case in Charity Hospital about a year ago. The patch on the upper part of the breast was then only about one-quarter of its present size, and was also much paler. It was diagnosed as psoriasis, and treated with chrysarobin. He afterward saw the case with Dr. Fox, and then there could have been three diagnoses made, viz., psoriasis, lupus erythematosus, and epithelioma. He would call the lesion behind the ear an epithelioma.

DR. FOX thought that the majority of members who would examine the patch on the breast by daylight would consider it a lupus erythematosus, and the condition existing behind the ear and on the back of the neck rodent ulcer or epithelioma.

DR. MORROW brought forward a

CASE FOR DIAGNOSIS.

In presenting the cases, Dr. Morrow said that some of the lesions were analogous to those seen in Dr. Fox's case just shown. He had made a provisional diagnosis of eczema. The best results had been obtained from the external use of benzoated collodion.

DR. BRONSON believed it to be a case of eczema arthritogenetica described by Bazin, as the patches were sharply circumscribed, dry, and no tendency to spread.

DR. FOX thought the lesion was an eczema; in some places there was a number of vesicles in groups resembling greatly dermatitis herpetiformis.

DR. ALEXANDER had seen the case in the hospital, and at first thought the eruption under the left nipple was psoriasis, but after a time, because of the greasy appearance of the scalp, he considered it seborrhœa.

DR. MORROW showed a

CASE OF ECZEMA OF CICATRICIAL TISSUE.

The patient, an Italian, five years ago received a cut on the arm, above the wrist, from an axe. The arm became painful, there was swelling, and abscesses formed, which were opened. Now there is a development of eczema over the inner, outer, and anterior aspect of the right forearm, chiefly situated upon cicatricial tissue.

DR. BRONSON said that he had seen a similar case, in which a man received a punctured wound; there was considerable loss of tissue, attended by oedema, which was probably due to the obstruction of the lymphatics. There was a copious secretion, and a condition resembling eczema madidans resulted. He thought that the lesion in Dr. Morrow's patient might be due to an obstruction of the lymphatics.

DR. ALLEN exhibited a

CASE OF TYLOSIS.

The patient was first seen in February, 1883, when she was suffering from anidrosis of the palms, the hands were calloused and fissured, and presented very much the appearance of an eczema. Now on the palms and back of the hands, as well as the forearms, the wrists, and around the ankles, are deep sago-like granules, and when left without treatment the epidermis becomes quite thickened and horny. The eruption never itched.

DR. BRONSON presented a

CASE OF ATROPHIA CUTIS PROPRIA.

Janet M., aged 4 years. The child has always been healthy, and there is no history of eruption in the family. The lesion was first noticed last January on the temple. At first it was red and a little swollen, but soon became white. Soon after this, spots were seen on the neck, supposed to be a loss of pigmentation caused by sun-burn; later, similar white spots on the back and chest were noticed.

Now, just above and anterior to the left ear is a spot about the size of a new five-cent piece, slightly depressed, and with a faintly marked reticulation, rather sharply defined, and of a dead-white color. The skin feels hard, and is not freely movable over the underlying surface. Extending from an inch below the left ear, along the junction of the neck with the chin, is a stripe about half an inch wide that reaches across the median line, and gradually disappears, fading away about two or three inches from the right ear. Its surface is smooth, shiny, and glossy as if glazed with a thin varnish. Its color is dead-white, especially toward the middle. At the lower border there is a marked increase of pigmentation. At its upper border, the crease formed between the chin and neck is pinkish. There are two patches near the left shoulder blade, and one in the left lumbar region, larger and irregularly shaped, with spurs or lines running down from it resembling the *lineæ albæ* of pregnancy or obesity. There is another smaller spot on the upper part of the right buttock, and a small one on the lower border of the right shoulder blade. All of these patches show a white centre and general glazed appearance, while toward the periphery the color is pinkish or lilac-colored, showing the vessels coursing over it more plainly, evidently indicating a thinning of the opaque epidermis. The epidermis is nowhere altered, except a little roughened in one spot just scratched. The patches are not sharply defined, and the pink of the border begins at the white centre and shades off gradually into the surrounding tissue. The centre is apparently white because of the

atrophy of the vessels, and the lilac zone of the patches is more pronounced when the surface is exposed to the cold air. The veins, as they enter these zones, become decidedly more distinct, showing great translucency of overlying skin. The sensibility of the patches, so far as can be ascertained, is not noticeably altered, and when some of them are pinched between the fingers they seem a little thickened; the one over the temple is somewhat hard and hide-bound; that on the neck appears to be more resistant to the touch than the surrounding skin.

In connection with this case, DR. TAYLOR mentioned that of a woman, aged 36 years, whose husband had syphilis, and in whom the chest, arms, neck, scapula, and inter-scapular regions were covered with a typical morphœa which had lasted for three years. There were twenty or thirty patches, varying in size from that of a half dollar to that of the palm of the hand, with violaceous borders and venules coursing through the patches. When the patches first made their appearance, they looked like erythema nodosum, and in the centre of each of these a whitening took place, and a violaceous border appeared.

DR. MORROW thought the case interesting and curious in its development. He did not understand whether the hyperchromia of the margin was due to a thinning of the skin or a hypertrophy of the cutaneous vessels.

DR. BRONSON said that his reason for exhibiting the case as one of idiopathic atrophy of the skin, and not as one of morphœa, was to elicit an opinion. What constitutes morphœa? This lilac border was due to a greater translucency of the skin in that situation; afterward, as the process goes on, and there is complete atrophy, we have a dead-white appearance. It is analogous to vitiligo, in which there is a heaping up of pigment at the edges of a patch. The small striations, seen in this case, were never found in morphœa.

DR. PIFFARD asked if in this case, as in *striae atrophicæ*, infiltration had preceded the disease, and if atrophy preceded by infiltration constituted morphœa.

DR. MORROW believed that in every case of morphœa the structural changes were first hypertrophic, then succeeded by atrophy. Some writers classed morphœa among the hypertrophies, others among the atrophies of the skin.

DR. FOX showed a

CASE OF PALMAR LESION.

The woman was shown at the Society about eight years ago. At that time the eruption presented similar appearances. Now there are several small points of eruption scattered over the palm of the right hand, and also on the fingers. The lesions present a great resemblance to syphilis. She has been under anti-syphilitic treatment without benefit. When she keeps her hands out of water the eruption is greatly improved. There is no eruption elsewhere.

DR. MORROW remembered the case as being under his care several years ago. He thought it remarkable that the lesions had remained so many years in the same form and in the same place.

DR. ROBINSON said that he was not prepared to call it syphilis; it might be an eczema or dermatitis.

DR. FOX said that the fact that it existed on one palm only and remained for twelve years was an argument against its being syphilis.

DR. ALLEN presented a

CASE OF ECZEMA.

Patient, a girl, was seen about two months ago for the first time. She then had an eruption of impetiginous eczema on the scalp, and the body was covered with scales. Now there are circular spots on the back and on the hands. In the centre of these patches the skin is healthy. There is also enlargement of the epitrochlear glands. The eruption made its appearance when the child was three years old, and has been present for the past six years. It was at one time supposed to be hereditary syphilis, but there is no history pointing to that. The

eruption on the scalp has disappeared under the use of carbolized oil, and the body has been dusted with starch powder. Internally, antisyphilitic treatment had been employed. The question was raised whether the enlargement of the epitrochlear gland could occur if syphilis were not present.

DR. KEYES did not think that because a lesion disappeared under the use of an antisyphilitic treatment it was necessarily syphilis. He had also found enlargement of the epitrochlear gland in the acute stage of suppuration, due to the spontaneous formation of an abscess.

DR. KEYES then showed a

CASE OF DISEASE OF THE NAILS.

The patient was a medical student. Eight years ago he had a patch of dry eczema on the back of the right hand. This remained one year, and finally disappeared under the use of mercurial ointment. The present malady came on the palm of the same hand, simply as a drying up of the epidermis with the appearance of scattered small round white areas, where evidently the skin is elevated with air beneath; there has never been any fluid present. The epidermis of the palms sheds off in pieces from time to time. All the nails of the right hand became affected, as at present, viz., a thickening of the matrix appeared beneath the free border of the nail, which apparently spread backward beneath the nail, and there showed through as chalky areas, leaving the glistening polished surface of the nail above the altered patch unchanged. There is also a ragged condition of the nails. The nails of the left hand are normal. The nails of some of the toes are similarly affected, but to a lesser degree. Occasionally, also, eczematous patches appear about and between the toes. The rest of the skin is in good condition. The general health is good. The present malady has remained practically unchanged for the past seven years. The patient's grandfather had a similar condition of the nails.

DR. ALLEN then read the paper of the evening, entitled :

SOME OF THE USES OF PYROGALLIC ACID IN DERMATOLOGY AND THE DANGERS ATTENDING ITS APPLICATION.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

PRICKLY HEAT—RECURRENT HÆMATEMESIS WITH URTICARIA—BILATERAL HERPES ZOSTER—ECZEMA FOLLOWING THE COURSE OF NERVES—PITYRIASIS MACULATA ET CIRCINATA—LUPUS—TREATMENT OF VASCULAR HYPERTROPHY OF THE NOSE—TURPENTINE INTERNALLY IN CUTANEOUS DISEASES—ANTIMONIAL WINE IN SOME SKIN DISEASES—COCAINE IN PRURITUS ANI.

Prickly Heat.—The following case has been recorded by Mr. Wharton as an example of "Prickly Heat" (*Lancet*, August 2, p. 190), a tropical disease which, he thinks, may occur in this country. A medical man, after passing the age of 30, and while in perfectly good health, suffered from continually increasing distress as each summer came round, owing to a papular eruption over the whole of the

back, and in considerable patches on the forearms; the eruption was accompanied by much "prickling," always increased by perspiration, and no treatment was of the least benefit, the eruption continuing from May to November. At last Mr. Wharton thought that perhaps the light short-sleeved gauze vests that the patient wore during the summer might have some share in causing the complaint, as they were too thin either to absorb sweat or to protect from sudden chills; he was therefore advised to wear throughout the summer the same thick, long-sleeved woollen vests which he wore in winter, with the happy result of complete cessation of the affection during the whole of one summer.

Recurrent Hæmatemesis with Urticaria.—Dr. Pringle communicated the following remarkable "Case of Recurrent Hæmatemesis with Urticaria," to the Clinical Society on January 9th: A gentleman, aged 51, with a good family history, suffered in 1872 from two attacks of ordinary urticaria. Several similar attacks occurred in 1878, and in 1879 they were very frequent and severe, the tongue, mouth, and fauces being involved, and a watery fluid vomited; in 1880, he was never free from urticaria, and at intervals of about two months he had very severe attacks, with vomiting, often lasting twenty-four hours at a time, and much blood. The attacks became less frequent, but more severe in 1881 and 1882, and in November, 1882, the blood vomited in one attack filled two hand-basins, besides saturating the bed. The next attack occurred in April, 1883, when he was seen by Dr. Pringle, who found bright pink wheals, nowhere purpuric, thickly studded over the trunk and extremities; the blood vomited filled a large hand-basin; recovery ensued, the patient, as was always the case, getting well very rapidly. Soon afterwards he had two unequivocal attacks of gout in the right foot and left hand, and subsequent urticarial and vomiting attacks were less severe and frequent, and better controlled by subcutaneous injections of morphine and ergotin; three days after an arrested attack, a copious tarry motion was passed. The immediate exciting cause of the attacks was nearly always exposure to cold, and during the intervals he was free from all pain, and other symptoms of gastric disorder or ulcer; the liver and spleen were of normal size, both during and between the attacks; the urine passed during the attacks never contained blood, and in the intervals was often loaded with urates, and contained an excess of uric acid, but no albumin nor sugar; the radial pulse was hard, and the second sound of the heart sharp at the base. Dr. Pringle believed that the hæmatemesis was due to capillary rupture, occurring when the gastric mucous membrane was in an urticarial condition. No exactly similar cases had been described, but Murchison had mentioned the case of a boy with urticaria tuberosa, purpura, and hæmorrhage from the bowels, kidneys, and urinary passages, accompanied by discharge of much uric acid.

Bilateral Herpes Zoster.—"A case of Double or Bilateral Herpes Zoster" has been narrated by Dr. Finny (*Brit. Med. Journ.*, Jan. 10, p. 67). A married woman, aged 40, had severe headache for four days, depriving her of sleep; pain extended all over the head, but was most severe on the right side; at the time of its first appearance she noticed a number of small red spots on the left side of the neck and shoulder, which were the seat of burning and soreness, and increased in size and number. At the same time the right ear became sore, and painful spots broke out through the hair on the back of the scalp on the right side. On inspection, characteristic erythematous patches of zoster, studded with vesicles of various sizes, were at once recognized, both sides being simultaneously affected, although at a somewhat dif-

ferent level: on the left side the symptoms chiefly followed the distribution of the descending sensory nerves of the cervical plexus, and were nearly limited to the upper part of the deltoid and pectoral muscles; while on the right side no patches occurred below the level of the thyroid body, the neck, face, ear, and scalp being the parts affected, corresponding to the distribution of the ascending branches of the second and third cervical nerves, the junction of the superficialis colli with the facial, and the greater and lesser occipital nerves. The chief interest of the case is that both sides were attacked at the same time, which is extremely rare.

Eczema Following the Course of Nerves.—Dr. Shearer has published an account of "A Case of Eczema following the course of the small sciatic and short saphenous nerves" (*Glasgow Med. Journ.*, Feb., p. 81). A thin healthy boy, aged 13, noticed, eighteen months before he was first seen, that the skin behind the left knee-joint became thick, rough, red, and itchy; this condition slowly extended downwards to the prominence of the calf, and upwards to the buttock, and within the last six months or so had spread still farther downwards to the little toe, and had undergone little or no change for four or five months. While spreading it was red, itchy, and "leeted a good deal." When seen, the eruption was dark-red, in many parts covered by thin scabs raised above the general surface of the skin; the margins were well-defined, and it extended in one unbroken band from the buttock to the toe, the neighboring skin being perfectly healthy; the breadth varied from a little more than a quarter of an inch to two inches, being broadest over the buttock; there were one or two outlying patches over the popliteal space and calf: the eruption was much furrowed, and its margins everywhere marked by a narrow bronzed line of discoloration. Treatment was unavailing, and about a month later the eruption assumed a warty character for about two inches above the heel, and was much elevated, dried, and cracked just above the insertion of the tendo Achillis. About the same time an attack of herpes zoster began to develop on the opposite thigh and hip, which ran their usual course. Dr. Shearer points out that the curious affection of the skin in this case corresponds roughly to the course of the main trunks of nerves, and considers, therefore, that the cutaneous twigs were not in themselves primarily affected.

Pityriasis Maculata et Circinata.—Writing "On the Disease of the Skin named Pityriasis Maculata et Circinata" (*Lancet*, Sep. 20, 1884, p. 185), Dr. Colcott Fox states that it has not hitherto been described in England. He refers to Dühring's paper (1880), and considers that the affection was first described by Gibert as pityriasis rosea (1860), and further by Bazin (1862), Hardy (1868), Horand (1875-6), and Vidal (1877). Dr. Fox has recognized five cases, of which he recites that of a child (Blanche) already recorded in this JOURNAL (April, p. 102) by Dr. Kinnier. He finds that the macules may evolve primarily on the limbs or trunk, that the eruption bursts out in profusion and acutely, and continues in a lessening degree for several weeks; he has not noticed (with Gibert and others) that it always begins on the chest, and fades on older parts pari passu with its extension elsewhere; he describes the eruption as consisting of small rosy macules, and notes that while fading it resembles tinea versicolor; he points out the distinction from psoriasis, and that it is not parasitic. It is not the same as the roseola annulata of Willan, but often strongly suggestive of roseolous syphilides, especially the tardy circinate variety.

The same subject was brought before the Clinical Society by Dr. Fox, on April 10, as "A Peculiar Form of Skin Disease." He also noticed the parasitic

form described by Vidal, and showed a specimen of the fungus (*Microsporon dispar*). Dr. Stephen Mackenzie considered this only a micrococcus, which might occur in any necrotic tissue. Mr. Jonathan Hutchinson thought these cases, which always began on the trunk, never on the limbs or palms, originated in articles of clothing worn next the skin too long, and had recommended silk instead of flannel vests, and had seen the eruption disappear without further treatment.

Lupus.—The subject of lupus has been considered in a variety of communications, chiefly bearing on treatment. In a "Narrative of an Instance of Cure of Lupus erythematosus" (*Brit. Med. Journal*, March 14, p. 535), Mr. Jonathan Hutchinson relates the case of a gentleman, aged 45, whom he first saw in 1881, with characteristic patches of erythematosus lupus on each side and on the ridge of the nose. He was in fairly good health, but had a feeble circulation and dusky ears. His skin had always been very irritable, and the lupus patches had been present about a year. Arsenic was given internally, and a weak lotion of tar and lead to bathe the patches. In 1883 his medical attendant wrote to say that he was worse, and it was decided to insist on the use of arsenic. In February, 1885, the patient called to say his lupus was quite well. White, thin, inconspicuous scars had taken the place of the former patches. The patient stated that his cure was unquestionably due to the arsenic, which was not at first taken regularly, but had been continued since 1883 for fifteen months; it caused a sharp attack of shingles, and made the eyes red and irritable, but in the end quite cured the lupus. It did not appear that any local remedy had been employed. Mr. Hutchinson has prescribed arsenic for many other cases of lupus erythematosus, but has never realized any definite result; perhaps it may have seldom been sufficiently pushed. The present case would certainly suggest a freer use of the remedy, but he fears that we shall find that it is by no means generally successful.

Dr. Matthews Duncan's paper on "Lupus of the Pudendum," has already found a place in this JOURNAL (April, p. 116). The same author has also written "on Hæmorrhagic Lupus of the Female Genital Organs" (*Edinburgh Med. Journ.*, July, 1884, p. 5). The paper is chiefly of gynæcological interest, and contains an account of four cases. He designates the disease "lupus" in accordance with general practice, but histological examination shows that it has not the same structural peculiarities as lupus elsewhere. There are many varieties: patches of redness, uniform or nodulated, hypertrophies, ulcerations, and inflammations; there is generally no increase of sensitiveness, and in ulcerations sensation is diminished; sometimes, however, the affected parts are extremely sensitive, especially when inflamed. The special character of the four cases given is bleeding, either slight and of long or short duration, or profuse and of short duration; in one case slight hæmorrhage lasted fourteen years; in another it was so sudden and profuse as to cause alarming faintness; in two cases the ulcerated surfaces bled freely on being touched, but in the case where it was most copious the parts did not bleed on repeated handling. Dr. Duncan considers that the disease is allied with a form of chronic vaginitis seen mostly in women after the menopause, and called senile.

A valuable paper on "Lupus and its Treatment" was read before the Academy of Medicine in Ireland, on December 19, 1884, by Dr. Walter Smith (*Dublin Journ. Med. Science*, February, p. 89). He found the frequency of lupus in Ireland to be 1 in 209, while in England and Scotland it was about 1 in 50 cases of skin disease. He reviewed the arguments in favor of its tubercular origin, and believed it was produced by an organized virus. Clinically, many observers had

recognized points of contact between scrofula and lupus, and had noted the frequent association of cheesy affections of the glands and joints with lupus. Besnier had found that of thirty-eight lupus patients, eight had well-marked physical signs of phthisis. Histologically, the close resemblance between a caseating miliary tubercle and a lupus-nodule had been often pointed out; recently Koch had found tubercle-bacilli in four excised bits of lupus skin, but found them only in giant-cells, and very sparsely distributed. Experimentally, both culture and inoculation experiments had yielded positive results. As to treatment, it was pointed out that if the tuberculous doctrine were accepted, it strengthened the position of those who advocated constitutional treatment, and especially antistrumous remedies; the different plans of local treatment were referred to, particularly linear scarification and erasion.

Dr. Stowers, writing on "the Treatment of Lupus" (*Brit. Med. Journal*, January 3, p. 11), has observed most satisfactory results from the combined use of the scoop and nitrate of silver. Volkmann's spoon, when applied with considerable force, breaks down and removes all diseased tissue, while the healthy structures are too tough to be injured. The operation should be performed under an anæsthetic, as much depends on the complete removal of every tubercle; after bleeding is arrested, the serous discharge from the wound should be soaked up with blotting paper, and then solid nitrate of silver applied, being pushed deeply into the holes and interstices left by scraping. The parts should be dressed with lint saturated with carbolized oil, and more oil allowed to run under the dressing next day, and when suppuration has commenced, carbolized oil dressings should be applied daily; when the sloughs are separating, carbolic lotion should be used for cleansing. The operation has to be repeated at intervals of six to eighteen months, sometimes several times.

"The complete destruction of disseminated patches of lupus vulgaris by a new double-screw excavator," is recommended by Mr. Malcolm Morris (*Lancet*, July 26, p. 141), who says that surgeons who have practised scraping, or scarification, or both, are often disappointed to find small isolated tubercles reappearing in the scar or in the margin of the patch; these are difficult to remove by the above process, but it is essential that they should be destroyed. To accomplish this, an instrument should be somewhat larger than the tubercle, so that when inserted it may firmly grip the surrounding tissue; it should possess many lacerating edges, whereby the nodule may be thoroughly ploughed up; and lastly, should be capable of rapidly penetrating to the bottom of the nodule. These requirements are attained by a double-threaded screw (which is figured), and the scar resulting from its use is pale, flat, and satisfactory.

Dr. Thin, continuing his comments "on certain new methods in the treatment of the diseases of the skin" (*British Med. Journal*, February 28, p. 423), points out that it is probably correct to say that there is no approach to unanimity as regards the methods generally applicable in the treatment of lupus. Scarification, at one time strongly advocated by Besnier, has now been superseded by another method, which is recommended with equal confidence. This has also been disappointed by scarification, as although great amelioration takes place, a complete cure is not often obtained. The foci of new growth, which continually reappear, require, as a rule, more energetic treatment. He then describes the "interstitial and discrete cauterization" by galvano- or thermocautery, which is now recommended by Besnier; the pyrogallic acid treatment as employed by Schwimmer, and the combination of scraping and pyrogallic acid, preferred by Dr. G. H. Fox, of New York.

Treatment of Vascular Hypertrophy of the Nose.—The following "Treatment of Vascular Hypertrophy of the Nose" is recommended by Dr. Stowers (*Brit. Med. Journal*, January 10, p. 68). In acute rosaceous acne, simple passive congestion with enlargement, or fibro-cellular hypertrophy, multiple punctiform scarification, by a special instrument with many small blades, gives good results. The nose should be fomented with hot water, held and compressed between the left finger and thumb, and rapidly punctured from base to apex. In three cases under treatment, for seven, seven, and five months respectively, the corresponding number of punctures in each case were 15,750, 11,150, and 52,200; usually from 500 to 3,000 are made at one sitting, at intervals of five days to a fortnight. The good results are attributable to local depletion, which allows the over-distended vessels to recover their tone, and to invisible scarring, which by after-contraction reduces vascularity.

Turpentine Internally in Cutaneous Diseases.—Among therapeutical papers, that by Dr. Crocker, "on the Internal Administration of Turpentine in Cutaneous Diseases" (*Practitioner*, March, p. 176) deserves notice. He believes that the turpentine reduce hyperæmia, and place the patient so far on the way to recovery that a short supplementary local treatment easily removes the remains of the lesion. He had used oil of turpentine as an external application for psoriasis for a long time in proper cases, and as he found that it also benefited parts of the eruption to which it had not been applied, he determined to give it internally. A case of an old man with general psoriasis of six years' duration is then described, who was given *ol. terebinth.* ℥ xv., gradually increased to 3 i t. i. d. during a month, for the latter half of which two pints of barley-water were taken daily; there was no albumin in the urine, and he left the hospital improved. He was re-admitted in a few days, and the drug was then increased to ℥ lxxv. t. d. (!). This brought on slight hæmaturia, which subsided on stopping the drug. No external treatment was employed in this case, and the improvement was most remarkable, but the cure not complete. The turpentine was tried in thirty other cases, and, in a few, completely removed the psoriasis; but in most there was great improvement up to a certain point, when some external treatment was required to complete the cure. In two cases only the drug had to be discontinued from slight strangury, and in three cases diminished on this account; in all these the dose was under ℥ xx. In three cases the drug had to be stopped for dyspepsia, and in one it was left off because it had no effect on the disease. Thirteen cases of eczema were treated by turpentine, and some got quite well. Dr. Crocker thinks use of the drug should be restricted to those cases in which there is no defect of the general health, and finally notes that it appeared to relieve pain and retard growth in two cases of cancer. It is contra-indicated in the following cases: Children under five years old; all who have unsound kidneys or irritable bladders; most cases of dyspepsia, and gouty subjects. It should be given in emulsion three times a day after meals, the last dose not within three hours of bedtime, and barley-water should be given freely from the very commencement of treatment.

Antimonial Wine in Some Skin Diseases.—Writing "on the Use of Antimonial Wine for Certain Diseases of the Skin" (*Practitioner*, March, p. 161), Dr. Kent Spender remarks that as this drug has a marked influence on catarrh of the lungs or bronchi, it is reasonable to suppose it may control catarrh of the skin. He relates a case of psoriasis, threatening to pass into general exfoliative dermatitis, in which antimonial wine ℥ xv. was given every two hours during the day for a week, and then for another week ℥ xx.

every three hours, or six doses daily, and afterwards the same dose four times a day. The result was great improvement; in seventeen days only a dull, reddish maculation was left, and recovery was uninterrupted. Toxically, there was no evil effect whatever, nausea especially was absent, and no sensible physiological action was produced; the author believes that success was due to the administration of comparatively small and frequent doses.

Cocaine in Pruritus Ani.—Mr. Malcolm Morris, in a note on "Hydrochlorate of Cocaine in Pruritus Ani" (*Brit. Med. Journ.*, January 24, p. 177), relates the case of a gentleman who had long suffered from this distressing complaint. A solution containing twenty per cent of the drug, with five per cent glycerin, was ordered to be painted over the extruded mucous membrane and neighborhood of the anus, three times at intervals of ten minutes, the parts being allowed to dry somewhat before moving after the third application. As the result, the patient slept quietly for seven hours. This method was persevered in night and morning for more than a week without any return of the pruritus; it was then omitted for two days, and the irritation returned as bad as ever, while resumption of treatment again gave relief. Dr. Cottle (*Brit. Med. Journ.*, February 7, p. 278) has tried the remedy in the following two cases: (1) A lady with extensive lichen planus and severe irritation, preventing sleep without narcotics; all usual local remedies were without benefit. A four-per-cent solution of hydrochlorate of cocaine was freely and repeatedly applied to and around the spots, without relief. (2) A lady with severe eczema of the limbs of long standing, the parts being red, exuding, and partially excoriated; there was most intense itching unalleviated by ordinary measures; a five-per-cent ointment of hydrochlorate of cocaine in vaseline was freely and frequently applied, and rubbed in as firmly as tenderness of the skin permitted: slight diminution of the irritation followed. He thinks if it is to do good it should be dissolved in fat or oil, and the condition of parts should be such as to allow of firm rubbing in so as to favor absorption. CAVAFY.

LONDON.

Selections.

A NEW METHOD OF TREATING TINEA TONSURANS

THE difficulty of treatment is a purely physical one; namely, the almost seeming impossibility of bringing any active parasiticide into contact with the tinea fungus—the epiphyton or trichophyton tonsurans, whose conidia revel and run rampant in the secure nidus of the hair and hair-bulbs—a soil so congenial that it seems to be in some cases ever fertile and fertilizing.

Keeping this point in view, I made a large number of experiments with a variety of drugs—some of them so-called remedies—upon hairs, chiefly human and equine. I will not burden this meeting, nor waste precious time, by going into details; but I may mention that I steeped hairs in acetic acid and water, in spirits of turpentine, in chloroform, in sulphocarbolate of soda, bisulphide of carbon, glycerin of carbohc acid, solution of iodide of potassium, etc., keeping the hairs in the liquids for weeks and weeks—some of them for months—but they underwent no important change.

Knowing that hairs and most chitinous matters are acted upon by the caustic alkalies, I next tried these, and, of course, speedily ascertained that hairs were freely soluble in them. I have complete solutions of hairs in liquor potassæ and liquor sodæ. But these alkalies, although they will dissolve the hairs, are not competent to destroy the activity of the conidia of the ringworm-fungus; and the next step was to make the potash-solution (I took this for preference) convey a conidia-destroying agent

I made another series of experiments on hairs, and also upon the common mould or fungus—the penicillium. I cultivated the fungus on damp corks, and then treated these corks with various applications. Wiping away a portion of the propagated fungus very carefully, and taking sketches of the denuded portions and the remaining fungus-covered parts, I applied to the denuded surfaces the following solutions: to some, liquor potassæ; to others, liquor potassæ containing some iodide of potassium; to others, glycerin of carbolic acid; to others, solution of bichloride of mercury; and to the remaining corks two solutions, the first containing liquor potassæ and iodide of potassium, and then a second solution containing perchloride of mercury dissolved in spirits of nitric ether. The important outcome of these experiments was this; namely, that, where the last two solutions had been applied, no fungus-growth occurred again on the surface of the corks, even when months had elapsed; the soil, in short, had become uncongenial.

I next made experiments upon pieces of soft wood, and upon hairs pressed firmly between two pieces of leather, to ascertain the penetrating powers of different solutions; or rather, I was working this out alongside with the last-mentioned series of experiments—for to be effective, remedies must, according to my theory, reach the roots of the hair. I came to the conclusion that with liquor potassæ containing iodide of potassium in solution, and then afterwards applying mercuric chloride dissolved in spirits of nitre, I obtained the best results. I used spirits of nitre, because this forms a very thin and mobile liquid. These results seemed to show that the most powerful combination of remedies was first of all the application of liquor potassæ containing in every ounce half a drachm of iodide of potassium; and, secondly, a solution of perchloride of mercury in spirits of sweet nitre, in the proportion of three grains to an ounce, or an aqueous solution of the mercuric chloride. . . . To summarize, I may state that I have treated about thirty cases in all, and with very good results; and, in addition, I have satisfactory statements from a few friends to whom I have confided my method.

The great feature which I contend for in my plan is that, by softening the hairs with liquor potassæ, the iodide of potassium is conveyed to the very hair-roots and bulbs, the spots where the conidia flourish and germinate in profuse abundance, and hitherto in comparative security. There, whilst the hairs are in a softened condition, the mercury-solution can penetrate, and then, coming into contact with the iodide deeply down, an important chemical action is set up, and biniodide of mercury is formed, just where it is most especially wanted.—A. J. HARRISON, *Brit. Med. Journal*, Sept. 5, 1885.

THE TREATMENT OF TINEA.

It may be concluded from this very brief consideration of the subject:

1st. That it is highly probable that alopecia areata may be a parasitical affection, as has been partially demonstrated by the microscopical investigations of Malassez, G. Thin, Lehlen, Eichhorst, Pellizari, etc.—or at least that there is in-

contestable clinical evidence in favor of its contagiousness—but that there are other species of alopecia areata, which are totally different, in respect to their mode of development, tendency to relapse, hereditary transmission, and non-contagiousness.

3d. That a correct diagnosis in cases of tinea is important for prognostic purposes, and also as determining the appropriate treatment, which, in any case, ought to produce no symptoms more serious than those which would result from the disease when left to run its own course.

3d. That prophylactic measures, judiciously applied, wherever children are crowded together (in families or schools), tend to diminish day by day the total number of sufferers from this malady. Keeping the hair cut very close, washing the head from time to time with soap, and when the disorder has been contracted, isolation of the patient and all his belongings, including the head itself by means of a cap, together with rigorous inspection of schools—such are some of these measures, whose good results are every day apparent.

4th. That, historically considered, the treatment of tinea (first established on a scientific basis by the discoveries of Schoenlein, Gruby, and Malmsten) may be divided into two epochs—that, now past and gone, in which it was conducted according to the principles of the humoral pathology; and the present, when we confine ourselves entirely to local measures. Between these, Bazin occupies the period of transition.

5th. That epilation, the pitch-cap, etc., etc., are processes which have come down to us from antiquity; that it is Bazin's chief merit to have recognized the advantages of the first, while he rejected the second, and also to have advocated the topical use of parasitocides.

6th. That the duration of treatment is in no degree lessened by the employment of the so-called parasitocides, and that when the eclectic method is resorted to (comprehending epilation, *zones de surveillance*, shaving the head, and the use of expulsive agents), from six months to two years are required for the cure of trichophytosis and favus, and from two to six months for the cure of alopecia areata; this implying merely the removal of the local symptoms, without regard to the occurrence of relapses. As to alopecias of nervous origin, or constitutional, their period of duration cannot be foretold with precision, since it is sometimes indefinite.

7th. That, before pronouncing the cure complete, after the hair has begun to grow again, the latter, together with the scratched-off epidermis, should be kept under microscopical examination for a certain length of time.

8th. That parasitocides, in reality, have no existence, and that, as was well said by M. Besnier at the Academy of Medicine: All these dermatophytes are alike refractory to any substances employed at a strength compatible with the vitality of the organic elements they inhabit; all the morbid alterations which they produce are favorably acted on by a variety of remedies, but none of them is actually cured until the parasite has spontaneously arrived at its fullest development, or until its expulsion has been brought about by desquamative irritation of the layers of infiltrated cells; hence it is that the treatment of these alterations requires on the part of the practitioner adequate experience and a peculiar degree of care and watchfulness; and hence it is not to be supposed for a moment that any single agent, or any one systematic method, can be indiscriminately applicable to all cases and all subjects.—MANUEL J. VENEGAS Y CANIZARES, *Thèse de Paris*, 1885.

MERCURY AND ALBUMINURIA.

At the congress for internal medicine, held at Wiesbaden in April, 1885, Dr. Fürbringer reported that he had found, out of a hundred chosen cases, eight syphilitics with perfectly healthy kidneys who developed albuminuria during mercurial treatment; the maximum of albumin being five per cent.

The internal and external exhibition of the mercury was followed by the same results which persisted during the whole of the treatment and disappeared some weeks after treatment was stopped.

The alterations in the kidneys were therefore not important, as was proven as well by microscopic examination.

In another series of one hundred cases of syphilis which had not been treated with mercury, or were no longer so treated, and in which the kidneys had been healthy, he was able to establish in twelve per cent an albuminuria consecutive to the syphilis.

This in every case was discovered in the stage of the roseola eruption. Here the urine contained formed cylinders which pointed to a light nephritis. This form of albuminuria gave way to mercurial treatment. Therefore he argues that the existence of albuminuria is not a contra-indication to mercurial treatment, which, on the contrary, should be prescribed as a necessity.—*L'Abeille Medicale*, Sept. 7, 1885.

TREATMENT OF PSORIASIS BY MEDICATED PLASTERS.

THE medicated plasters constitute a neat and convenient method for the treatment of psoriasis, which has an additional advantage in that it may be carried out by the physician himself.

The applications require to be renewed less frequently than when simpleunctions are employed. They are usually contra-indicated if the disease is seated on the face or scalp.

The chrysophanic plasters appear to be as efficacious in cases of psoriasis as the ointment compounded of the same agent, while unpleasant symptoms are less liable to be occasioned by their use. The average duration of treatment with the plasters is about three weeks.

They exert no influence in the prevention of relapses.

Pyrogallic acid plasters are less serviceable than those of chrysophanic acid.—J. BELLAN, *Thèse de Paris*, 1884.

Received.

L. DUNCAN BULKLEY, A.M., M.D. Acne: Its Etiology, Pathology, and Treatment. G. P. Putnam's Sons, New York. Will be noticed in next number.

P. G. UNNA. Clinical History and Treatment of "Lichen Ruber."

———— Die neueren Fortschritte in der Therapie der Hautkrankheiten.

———— Die Nervenendigung in der menschlichen Haut.

———— Ueber medicinische Seifen.

———— Heilung eines Falles von Lepra tuberosa.

———— Die Stauungsdermatosen des Unterschenkels.

R. B. MORISON. Ergebnisse der Behandlung von Hautkrankheiten mit Unuaschen Präparaten.

GREENOUGH. Five cases of Cerebral Symptoms in Early (secondary) Syphilis. (Reprint.)

_____ Clinical Notes on Psoriasis. (Reprint.)

_____ The Routine Treatment of Venereal Diseases. (Reprint.)

Items.

SYCOSIS TREATED WITH OLEATE OF COPPER.—Dr. S. Armer reports that he cured himself of a sycosis from which he had suffered for twenty-five years, with a twenty-per-cent ointment of oleate of copper. The duration of treatment was only four weeks.—*Therapeutic Gazette*, Oct., 1884.

TINCTURE OF PULSATILLA IN THE TREATMENT OF ORCHITIS.—Martel de St. Malo, in a correspondence with Dujardin-Beaumetz, reports satisfactory results from the use of pulsatilla in epididymitis. He refers to its successful use in America.—*Bull. Génér. de Thérapeutique*, Feb. 15, 1885.

THE CURETTE IN THE TREATMENT OF SYPHILITIC LESIONS.—M. Spillman (de Nancy) has recourse to scraping with the curette of Volkmann, and the subsequent dressing of the wound with the *liqueur de Van Swieten* (Hydrarg. Bichloridi, 1 pt.; Alcohol, 100 pts.; Distilled Water, 900 pts.) in the treatment of old serpiginous ulcerating syphilides, and of phagedenic chancres. In five cases in which he had occasion to practise this treatment, he attained a prompt and permanent cure.—*Le Progrès Médicale*, Sept. 5, 1885.

TREATMENT OF ERYTHEMA NODOSUM.—The raised patches of erythema nodosum which are sometimes found over the tibæ are sometimes very painful, and usually slow in receding. I have acted in accordance with the view that this disease is due to inflammation of the lymphatic vessels and spaces, and that it is more closely allied to erysipelas than any other disease; I have, therefore, treated it antiseptically with sulphurous acid. In three cases treated in this manner, I have met with marked success, the pain being relieved and the patches rapidly subsiding. My method is to soak lint in a mixture of equal parts of fresh sulphurous acid of the British Pharmacopœia and hot water heated to boiling point; the lint is then wrung out and placed over the patches. When it cools, it is changed for another piece.—W. E. BUCK, M.D., *Brit. Med. Journal*, No. 1,278, 1885.

THE TREATMENT OF FROST-BITTEN FINGERS AND TOES.—Dr. Lapatin, in the *Proceedings of the Caucasian Medical Society*, advises that fingers and toes which have been slightly frost-bitten, and which subsequently suffer from burning, itching, and pricking sensations, should be painted, at first once, and afterwards twice a day, with a mixture of dilute nitric acid and peppermint water in equal proportions. After this application has been made for three or four days, the skin becomes darkened and the epidermis is shed, healthy skin appearing under it. The cure is effected in from ten to fourteen days. The author has found this plan very effectual amongst soldiers, who were unable to wear their boots, in consequence of having had frozen feet. They were, in this way, soon rendered capable of returning to duty.—*Brit. Med. Journal*, Sept. 5, 1885.

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